REPUBLIC OF KENYA

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When replying please quote

DENTAL INTERNSHIP TRAINING FACILITY INSPECTION / DATA FORM

1. DATA

Name of Institution .....

Postal Address .....

Physical Address.....

Telephone No. .....Fax.....

E-Mail .....

Province.....County.....Town.....

Medical Director/Medical Superintendent.....

Health Administrator (*where applicable)* .....

Nursing Officer incharge.....

Category of Institution: ----------number of interns to be trained----------

Brief History of the institution (where applicable)

.....

.....

.....

Patient attendance (daily average) .....

2. **Human Resource**

Recognized Specialists	**Names**	**Reg.No.**
(a) Oral and Maxillofacial Surgery	(1) ----------	----------
	(2)----------	----------
(b) Paediatric Dentistry and Orthodontics	(1) ----------	----------
	(2)----------	----------
(c) Conservative and Prosthetic Dentistry	(1) ----------	----------
	(2)----------	----------
(d) Periodontolgy	(1) ----------	----------
	(2)----------	----------
(e) Others (specify)	(1)----------	----------
	(2) ----------	----------
	(3)----------	----------
	Total No.	

Dental Officers Intern	(1) ----------	----------
	(2)----------	----------
	(3) ----------	----------
	(4) ----------	----------
	(5) ----------	----------
	(6) ----------	----------

Auxiliary Health Personnel

(a) Community Oral Health Officers- ----------

(b) Nurses.....

(c) Dental Laboratory Technologists- ----------

(d) Other (Specify)…….

2. Physical Facilities

i. Fully Functional Dental Chair (one unit per intern) ----------

ii. Amalgamator (s) ----------

iii. Light cure machine(s) ----------

iv. Ultra sound Scalar(s) ----------

v. Full range of instruments/accessory equipment ----------

vi. Dental materials and supplies ----------

vii. Electricity and energy back-up .....

viii. Resource centre/library with dental literature ----------

a. Seating capacity ----------
b. Current Journals/ reference books_____ Internet connection

Yes	No

ix. Internal Accommodation for interns

a. Number of flats/houses----------
b. Night-call rooms----------
c. Medical Insurance

Yes	No

x. Waste management

-Incinerator _____

-Pit _____

-Sluice rooms _____

-Sharps container _____

Support Facilities

i. Dental Radiology (Intra oral and Panoramic x-ray equipment ----------

ii. Dental Prosthetic laboratory ----------

iii. In patient facility ----------

iv. Theatre .....

iv. Pharmacies ----------

v. Pathology laboratory ----------

vi. Accident and emergency facilities ----------

3. **Registered and running Continuing Professional Development (CPD) Programs?**

Yes	No

CPD Coordinator Name:----------Reg. No.-----

4. **Availability of Standard Operating Procedures (SOPs)**

Yes	No

5. **Availability of a Strategic Plan?**

Yes	No

6. **Presence of a Maintenance Unit**

Yes	No

(with Technologist competent in Dental Units)

Yes	No

7. **Presence of Registry and Stores**

Yes	No

8. **Availability of Occupational Safety Facilities (e.g Eye wash facility/exposure control protocol)**

9. **Remarks:**

Names: -_____Date: _____Signature:_____

Medical Director/Medical Superintendent

BOARD OFFICIAL USE ONLY

Comments by Interns

Comments by intern supervisors, Specialists, DOs

FINDINGS

RECOMMENDATIONS

Inspection Team

	Name	Designation
1.		
2.		
3.		
4.		

Dated:_____