APPLICATION FORM FOR DECLARATION AS A HEALTHCARE SERVICE PROVIDER

A. FACILTIY INFORMATION

Licensed /Trading Name of institution:	
Plot No.	Building:
Postal Address: P.O. Box	Town:
County:	Street:
Nearest NHIF Office:	Tel Landline:
MOH Master Facility Code:	Mobile Number:
NHIF Hospital Code	Email address:
Licensing/Health Regulatory Body:	Licence Serial Number:
Number of Licensed Beds / Dental / dialysis Chairs:	KEPH Level: I,II,III,IV,V,VI
Hospital Category:	KEPH Tier: 1,2,3,4
Health Facility KRA Pin:	Inpatient Choice of Contract: B/C
Application Tracking Number:	Application Type: Private/Mission

B: Services Offered (Tick where applicable)

Outpatient only	Inpatient only	Both In & Out patient	Maternity	Optical	Dental	Renal	Oncology	Rehabilitation	Radiology	Surgery
Other(Specify)										

C. SELF ASSESSMENT ON UNIT SERVICE STATUS

	UNIT OF SERVICE	(SERVICE AVAILABILITY YES/NO)
1	Health Facility Infrastructure	Yes/No
2	Leadership, clinical governance, patient's rights and human resource	Yes/No
3	Infection, prevention and Control	Yes/No
4	Consultation services	Yes/No
5	Maternity unit	Yes/No
6	General wards	Yes/No
7	Theatre	Yes/No
8	Pharmacy	Yes/No
9	Laboratory	Yes/No
10	Radiology	Yes/No
11	Other support services	Yes/No
12	Safety and Risk management	Yes/No
13	Population engagement & facility outcome	Yes/No
14	Eye unit	Yes/No
15	Dental unit	Yes/No
16	ICU	Yes/No
17	Renal	Yes/No
18	Rehabilitation	Yes/No

Please note that there are no applicable fees or charges for this process

D. DOCUMENTARY REQUIREMENTS (Only Applicable for Mission and Private Facilities)

Kindly attach the following documents.

1. Certified true copy of Certificate of Registration by the Kenya Medical Practitioners and Dentists board
2. Certified true copy of valid license to operate as a medical facility by Kenya Medical Practitioners and Dentists board.
3. Certified true copy of Certificate of Incorporation by the Registrar of companies.
4. Endorsed List of Owners/ proprietors / Directors of the medical facility signed and dated.
5. Certified true copy of Certificate of Registration of Business Name
6. Certificate of compliance by NHIF.
7. Complete self-assessment Manual

E. HOSPITAL ENDORSMENT

I hereby declare that the above information is correct to the best of my knowledge.

Hospital Representative's

Names_____Sign_____Official Stamp & Date__/___/____

F. For Official Use: Branch Office Validation

We hereby confirm that the application form is duly completed and all the required documents have been attached and validated.

Senior Quality Assurance Officer

Names_____Sign_____Date__/___/____

Branch Manager

Names_____Sign_____Official Stamp & Date__/___/____