APPLICATION FORM FOR DECLARATION AS A HEALTHCARE SERVICE PROVIDER

A. FACILITY INFORMATION

Licensed /Trading Name of institution	
Plot No	Building
Postal Address: P.O. Box	Town
County	Street
Sub County	Geo Coordinates
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
Hospital Category	KEPH Tier
Health Facility KRA Pin	Inpatient Choice of Contract
Application Tracking Number	Application Type

B: Services offered (Tick where applicable)

Outpatient only	Inpatient Only	Both in &out patient	Maternity	Optical	Dental	Renal	Oncology	Rehabilitation	Radiology	Surgery

C. SELF ASSESSMENT ON UNIT SERVICE STATUS

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

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

DOCUMENTARY REQUIREMENT

Kindly attach the following up to date documents

1. **Certified true copy of certificate of registration by Kenya Medical practitioners & Dentist Council. (KMPDC)**
2. **Certified true copy of Licence to operate a facility in Kenya by Kenya Medical practitioners & Dentist Council (KMPDC)**
3. **Certified copy of Business registration name or Certificate of Business incorporation.**
4. **Certified copy of CR 12 for facilities with certificate of incorporation or CR 13 for facilities with certificate Business registration.**
5. **Certified copy of Certificate of Compliance by National Hospital Insurance Fund.**
6. **Certificate of change of name applicable to facilities requesting for change their name.**

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……...

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

Branch Manager

Names ……Sign…… Official Stamp & Date

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