**APPLICATION FORM**

**Accreditation for Hospital & Healthcare Consultant Organization**

Photo of authorized Person

1. Applicant Organization
2. Name:
3. Head Office- address, email, telephone:
4. Branch Office(s) - addresses, email, telephone:
5. Website:
6. Name of Head of the Applicant Organization with designation:
7. Contact person details:
   1. Name :
   2. Tel No.:
   3. Mobile:
   4. Email:
8. Application for (please mark (√) the appropriate status):
   1. Initial Accreditation (New)
   2. Re- accreditation
9. Legal Status of the Organization (please mark (√) the appropriate status):
   1. Public/Private/Government
   2. Company/ Partnership/ Proprietorship/ Registered Society
   3. Research/Academic Institute
   4. Industry Association
   5. Others (please specify and attach necessary evidence)

1. Date of Registration/Incorporation (DD/MM/YYYY):

(Attach copy of certificate of incorporation/registration)

1. Year of Establishment:
2. Details of consultancy provided in Hospital & Healthcare Organization

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sr. No.** | **Project in which Consultancy Provided** | **Year** | **Duration** | **Remark** |
|  |  |  |  |  |
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1. Other services provided by Consultant Organization (if any like Training etc.)
2. If involved in Training, please provide details of Training (Use Separate Sheet if required)

a) Topic b) Duration

1. Is Institution affiliated with any Regulatory Body?
   1. If YES, please mention the following:

a). Name of the Body (s) with which affiliated: ----------------------------

b). Affiliation No. and validity: ----------------------

c). Year of affiliation: -----------------------

**(Note: Attach affiliation certificate)**

1. Organization structure (with details of locations/ associates etc)
2. Consultancy Facilities –

Summary of personnel involved in hospital & health Care consulting services –

1. In house Experts –
2. Empanelled/ Visiting Experts –
3. Administrative staff -

**(Note: Attach list of proposed experts with their CV as per Annexure 3 in application)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sl. No.** | **Name** | **In house /**  **Emp.** | **Educational**  **Qualification** | **Training Certificates, if any** | **Experience**  **(Years )** | **Consultancy experience**  **(Years)** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

***Kindly ensure that the proposed experts meets the qualification and experience requirements as prescribed in the Appendix 1 of the Scheme.***

**D. Other Relevant Information**

1. Have you developed a Quality Manual meeting the requirements CQAS of the Scheme as mentioned in Appendix 2) Yes/ No

(Attach Consultancy Quality Assurance System (CQAS), Institution Brochure and Associated Documents.)

1. Please find enclosed the Demand Draft/ Cheque (Delhi only) no……………………. for Rs………………………….. dated ………………. drawn on……………….in **favour of Quality Council of India,** payable at New Delhi towards the application fees **(Enclosure)**
2. **Declaration**

We have carefully read all NABET guidelines for Accreditation of **Hospital & Healthcare Consultant Organization**. We confirm that the information in support of the application is correct to the best of our knowledge. We agree to abide by the code of conduct and terms & conditions of NABET as applicable from time to time.

We authorize NABET to make any enquiry as deemed fit as part of the reviewing process. We understand that in case any information is found to be incorrect, it may result in rejection of this application and/or disqualification. We authorize NABET to utilize the information provided in this application for legal, research, training, sharing with other IPC members and/or for any other purpose as may be deemed fit by NABET.

If accredited, we commit to notify NABET immediately of any changes in the status where information regarding such changes, if declared may affect the consideration for Accreditation of the organization

Authorised Signatory

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:

Place:

# Checklist

### List of Enclosures (to check) Enclosed

1. Registration Certificate Y/ N
2. Organization chart Y/ N
3. Consultancy brochure/promotional material developed Y/N
4. List and resumes of experts/staff (indicating qualification & experience) Y/ N
5. Admin. support staff (indicating qualification and experience) Y / N
6. Details of Grants received in last 3 years, if any Y/ N
7. Summary of Audited Financial Reports of last 3 years Y/ N
8. Consultancy Quality Assurance System along with SOPs and other Y/N
9. Application Fee (as applicable) Y/N

**GENERAL INSTRUCTIONS**

* + All columns of application form **must be typed**.
  + Copies of all the relevant documents should be sent with the application.

**Resume Format**

**Accreditation for Hospital & Healthcare Consultant Organization**

Affix Passport Size Photograph

**Consultant/Expert Resume Format**

Dr./Mr./Ms./Mrs/.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(First Name) (Middle Name) (Last Name)

1. Status in the Organization: In-house Full Time Visiting/Empanelled

2. Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Office Address\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­

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Pin Code \_\_\_\_\_\_\_\_\_\_\_

4. Tel. No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. Fax No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Office

7. Mailing address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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8. General Education (Senior Secondary)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Period**  (Year) | **Board** | **Qualification** | **Educational Institution & Address** | **Subjects** | **Grade** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

9. Professional Education:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Period**  (Years from-to) | **Qualification**  **(Degree/diploma)** | **University/Institution Name & Address** | **Subject/**  **Discipline** | **Grade /**  % Marks |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

10. Registered / recognized training courses attended:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sr. No** | **Course Name** | **Attended** | **Conducted By** | **Duration & Dates** | **Result** |
| 1. | NABH Assessor Training Course | Y/N |  |  |  |
| 2. | Programme on Implementation of NABH Hospital Standard | Y/N |  |  |  |
| 3. | Other Courses |  |  |  |  |
|  |  |  |  |  |  |

11. Membership of Professional Bodies:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sr.No.** | **Professional Body (Name & Address)** | **Membership** | | **Valid Till** |
| **Grade** | **No.** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

12. Experience (Please write in chronological order with present experience listed first):

*A. General:*

| **Period**  **(Month and Year)** | **Organization with address** | **Department** | **Designation** | **\*Role/Duties/ Responsibilities** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |

B. Specific experience related to Hospital & Healthcare Consultancy:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S. No** | **Name of the Employer** | **Complete Name of the Project** | **Roles and Responsibilities (Nature of Experience)** | **Period &**  **Year** |
|  |  |  |  |  |
|  |  |  |  |  |

**13.** **Declaration by the applicant**

I attest that the above information relating to my education and experience is correct. I do understand that any incorrect information will result in the disqualification of self and the organizational accreditation with NABET.

I hereby declare that I am not working as Assessor for NABH.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

**14**. **Declaration by the Consultant Organization**

The above information in relation to Dr./Mr./Ms. ………………………………………………… has been verified and found to be correct.

Dr./Mr./Ms. ………………………………………………… not giving his/her service as Assessor for NABH.

I understand in case the information is found to be incorrect it may result in the rejection/ suspension of this application for the accreditation of Hospital & Healthcare Consultant Organization.

Attested By

Authorized Signatory:

Name

Designation

Date

Place

## **Annexure 2**

**DECLARATION OF ACCEPTING NABET’S CODE OF CONDUCT**

### C.E.O. / Head of Applicant Consultant Organization

This is to confirm that I ………………………., working as CEO/ Head of agree with the Code of Conduct (Section 4.3 of Scheme), conditions of accreditation of NABET and give an undertaking that I would abide by the stated conditions for all activities pertaining to Consultancy Services/ Activities.

I also understand that awarding/ continuation of accreditation of my organization is subject to continual compliance to conditions of accreditation.

Name ………………………………………………………………

Designation ………………………………………………………………

Date ………………………………………………………………

Signature ………………………………………………………………

## **Annexure 4**

**MOU/Agreement of Visiting /Empanelled Expert**

Written MOU/Agreement shall be signed between the organization and empanelled expert whose services are used for conducting consultancy.

Such MOU/Agreement should include:

1. Name of the HAH expert & Consultant Organisations
2. Duration of association
3. Specific roles & responsibilities and acceptance of visiting expert
4. Information regarding associated with any other HAH consultant organisations