



NHIS-F2

SERIAL NO...

**CREDENTIALING OF HEALTH CARE FACILITY  
APPLICATION FORM**

**1. Name of health care facility** .....

**1b. Did facility used a different name in the past? If yes then state the previous name of facility**

.....

**2. Type of Facility. Tick the appropriate box:**

- |   |  |
|---|--|
| a) <input type="checkbox"/> CHPS Compound                             | b) <input type="checkbox"/> Maternity Home         |
| c) <input type="checkbox"/> Health Centre                             | d) <input type="checkbox"/> Clinic                 |
| e) <input type="checkbox"/> Polyclinic                                | f) <input type="checkbox"/> Primary Hospital       |
| g) <input type="checkbox"/> Secondary Hospital                        | h) <input type="checkbox"/> Tertiary Hospital      |
| i) <input type="checkbox"/> Pharmacy                                  | j) <input type="checkbox"/> Chemical Shop          |
| k) <input type="checkbox"/> Laboratory                                | l) <input type="checkbox"/> Ultrasound Scan Centre |
| m) <input type="checkbox"/> Specialized Care                          | n) <input type="checkbox"/> Other .....            |
| i) <input type="checkbox"/> Eye   ii) <input type="checkbox"/> Dental | If n) above specify                                |

**3. Facility Ownership. Tick the appropriate box:**

- |  |  |
|--|--|
| a) <input type="checkbox"/> Government       | e) <input type="checkbox"/> Public Private Partnership (PPP)   |
| b) <input type="checkbox"/> CHAG             | f) <input type="checkbox"/> Ahmadiyya Health Services of Ghana |
| c) <input type="checkbox"/> Quasi-Government | g) <input type="checkbox"/> Mission (other faith based)        |
| d) <input type="checkbox"/> Private          |  |

**4. Category of Application. Tick the appropriate box:**

- |  |  |
|--|--|
| a) <input type="checkbox"/> New Application                          | b) <input type="checkbox"/> Upgrade          |
| c) <input type="checkbox"/> Renewal:                                 | d) <input type="checkbox"/> Re-accreditation |
| If 'c' above, when did your last credential expired/expiring .....   |  |
| e) <input type="checkbox"/> Additional service: Type of Service..... |  |
| f) <input type="checkbox"/> Other.....                               |  |

**5) Type of Insurance. Tick the appropriate box:**

- a)  National Health Insurance Scheme (NHIS)   b)  Private Scheme   c)  Both

If 'b' or 'c' above, please list the Private Health Insurance Schemes that you will provide services for:

.....  
.....

**6) Registration of company with Registrar General's Department:**

Business Registration Number	Date Registered	Date Last Renewal

**7) Registration of health facility with appropriate regulatory body/bodies:**

Name of Regulatory Body	Registration Number	Date Registered	Date Last Renewal

**8) Date health facility commenced service provision**

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**9) Address:**

Street address/Location	
Postal address	
Town/City	
District	
Region	
Tel number	
Cell phone number	
Fax number	
Email	
Website	

**10) Chief Executive/ Administrator/ Proprietor:**

- i. Name -----
- ii. Position-----
- iii. Contact number (cell phone) -----

Institution (s) Attended	Qualification (s)	Date & Year of Completion

**11) Does Chief Executive/Proprietor/Administrator own/manage other health care facilities?**

Yes  No

**11b) if yes, please list.**

*(Please use the following format to list your other health facilities)*

Name of facility	Region	District	Ownership	Facility type	Credentialing status

**12) Services offered: Tick the appropriate box:**

- i.  Out-patient                      ii.  In-patient (24hours)                      iii.  Maternity
- iv.  Ophthalmology                      v.  Surgery                      vi.  Pharmacy
- vii.  Chemical shop                      viii.  Laboratory                      ix.  Ultrasound scans
- x.  Diagnostic X-ray                      xi.  CT scan                      xii.  Dental
- xiii.  Orthopaedics (Specialist)                      xv.  Pathology (Specialist)
- xvi.  Other

**12b) If xvi. above is applicable, please specify:**

.....  
 .....  
 .....

**13) Bed capacity of health care facility? (Please indicate number).....**

**14) Details of Bank Account**

- a. Bankers..... b. Branch.....
- c. Account Name.....
- d. Account Number.....

**15) Key Professional Staff**

Type of Professional	Total No. of Professional (s)	Type of Professional	Total No. of Professional (s)
Medical Practitioners		Radiographers/X-ray Technicians	
Nurses		Medical Assistants	
Midwives		Doctor Anaesthetist	
Nurse-Midwives		Nurse Anaesthetists	
Pharmacists		Dentists	
Dispensing Technicians		Ophthalmologists	
Laboratory Technologist		Other (Please specify)	
Laboratory Technicians			

**16) Attachments**

Please attach copies of the following to your completed Application Form:

- a. Copy of Certificate of Registration of your facility with the Registrar General’s Department
- b. Copy of Certificate of Registration of your facility with appropriate regulatory body/bodies
- c. Proof of retention of your facility with regulatory body/bodies
- d. Copies of Certificates of qualification of heads of departments/units and all professional staff
- e. Proof of retention of heads of departments/units and all professional staff with regulatory body/bodies where applicable.
- f. PIN of nurses/midwives where applicable
- g. List of names of all professional staff, indicating whether they are full-time or part-time. Please use the format shown below.
- h. Receipt of payment of applicable Accreditation Application fee.

**17) Format for listing names of professional staff (See under 15 above)**

Please use the following format to list your professional staff.

Name of Professional	Rank / Position	Please tick whether permanent or temporary		If temporary /locum, permanent place of work
		Permanent	Temporary/locum	

**18) Responsibility**

A credentialed health care facility must notify the AUTHORITY within eight (8) weeks when there is a change in the information in this application herein submitted.

**19) Declaration**

I, ....., the Chief Executive/  
Administrator/Proprietor of .....

hereby declare that the information given above is correct and that I will be responsible for any falsehood provided.

Signature ..... Date .....

**OFFICIAL USE ONLY**

Received by.....

Receipt No.....

Signature of Officer..... Date.....