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) □ CHPS Compound
b) □ Maternity Home
c) □ Health Centre
d) □ Clinic
e) □ Polyclinic
f) □ Primary Hospital
g) □ Secondary Hospital
h) □ Tertiary Hospital
i) □ Pharmacy
j) □ Chemical Shop
k) □ Laboratory
l) □ Ultrasound Scan Centre
m) □ Specialized Care
n) □ Other …….
i) □ Eye ii) □ Dental
If n) above specify

3. Facility Ownership. Tick the appropriate box:

a) □ Government
e) □ Public Private Partnership (PPP)
b) □ CHAG
f) □ Ahmadiyya Health Services of Ghana
c) □ Quasi-Government
g) □ Mission (other faith based)
d) □ Private

4. Category of Application. Tick the appropriate box:

a) □ New Application
b) □ Upgrade
c) □ Renewal:
d) □ Re-accreditation

If **'c'** above, when did your last credential expired/expiring ……..

e) □ Additional service: Type of Service……....

f) □ 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

day	month	year

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……..