



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

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



**DOCUMENTARY REQUIREMENT**

Kindly attach the following **up to date** documents

1. Kenya Health Professional Oversight Authority Approval letter from the Ministry of Health
2. Certified true copy of certificate of registration by Kenya Medical practitioners & Dentist Council. (KMPDC)
3. Certified true copy of Licence to operate a facility in Kenya by Kenya Medical practitioners & Dentist Council (KMPDC)
4. Certified copy of Business registration name or Certificate of Business incorporation.
5. Certified copy of CR 12 for facilities with certificate of incorporation or CR 13 for facilities with certificate Business registration.
6. Certified copy of Certificate of Compliance by National Hospital Insurance Fund.
7. Certificate of change of name applicable to facilities requesting for change their name.
8. **Certified copy of KRA Tax Compliance Certificate.**

**E. HOSPITAL ENDORSEMENT**

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**