APPLICATION
For
ACCREDITATION OF HEALTHCARE INSTITUTION

KERALA ACCREDITATION STANDARDS FOR HEALTHCARE INSTITUTIONS (AYUSH)

Part. A (General Communication Details) Unique ID of the Institution (*to be issued by NAM*)

1. **Name of the Healthcare Institution:** (as in the official records)

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2. **Contact Details of Healthcare Institution:**

Street Address :____

City / Town :____

District :________________________________ **PIN :** ☐☐☐☐☐☐

LSGI :____

Official e-mail address : ____

Office landline Phone : ☐☐☐☐☐☐☐☐☐☐☐
(with STD code)

Location of Healthcare Institution : *(Put √ as applicable)* ☐ Urban ☐ Rural

Does the Healthcare Institution have split location(s) / peripheral units / sub centres ?
(Put √ as applicable) Yes ☐ No ☐

If yes, address of the other location(s) and distance from main location
____
____
____

3. **Date of establishment :** ☐☐☐☐☐☐☐☐
D D M M Y Y Y Y

(Give reference to Government Order No. & date)
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4. **Date of commencement of clinical functions :**

☐☐☐☐☐☐☐☐
D D M M Y Y Y Y

5. **Contact details of the Head of the Institution / Internal Accreditation Co-ordinator :**

Name : ____

Designation: ____

E-mail: ____

Mobile: ☐☐☐☐☐☐☐☐☐☐

Part. B (Service Delivery Details)

6. **Healthcare Institution particulars:** *(Not applicable for institutions without IP)*

   a. **Total Number of Beds that have been sanctioned :** ☐☐☐
   b. **Total Number of Beds currently functional (in operation) :** ☐☐☐

Unit / Wing / Ward	Number of Beds
• Male Ward	
• Female Ward	
• Geriatry	
• Paediatrics	
• Ante-natal / Post-natal	
• Neo-natal	

Other Wards	Number of Beds

   c. **Healthcare Institution layout:**
      i. Number of buildings ________________
      ii. List the areas / departments / units floor wise for each building in a separate tabular sheet attached to this form.
      iii. In case of split location the layout for each of the addresses must be given.

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   d. **Does the Healthcare Institution provide treatment through other AYUSH Systems of Medicine (other than the main one):**

   ☐ Yes ☐ No If yes, please specify the system : ______________________

   e. **OPD & IPD data**

OPD DATA (Past 2 years)

Year	Total Number of Patients

IPD DATA (Past 2 years) *(Not applicable for institutions without IP)*

Year	Total Number of Patients Admitted OR Average Bed Occupancy Rate

7. Ten most frequent clinical diagnosis observed among the Patients (OP / IP):

i. .... vi. ....
ii. .... vii. ....
iii. .... viii. ....
iv. .... ix. ....
v. .... x. ....

8. Scope of Accreditation - Broad Specialities in the Healthcare Institution:

Speciality / Wing / Project / Services	Mention whether this service is provided daily or on particular / fixed days	Average daily of Out patients during the Previous Calendar Year *(if applicable)*	Average daily In Patients during the Previous Calendar Year *(if applicable)*	Number of Consultants *(if applicable)*
Among the above please list the services which are outsourced if any:				

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Authorised Signatory (Head of Institution)

Name: _______________________________

Place : (space for Office seal)

Date :

(Space for Designation seal)