THE NATIONAL HEALTH INSURANCE FUND (NHIF)

APPLICATION FOR ACCREDITATION OF A PHARMACY/DLDM

Receipt of non-refundable application fee should be attached when returning this form

(To be filled by all Health Facilities Registered by Ministry of Health)

Facility Name ----------

Registration number by the Ministry of Health /Pharmacy Council----------

Business account name of the facility (Payee details) ----------

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1. Type of Health Facility (tick appropriate option).

A. Wholesale & Retail Pharmacy	
B. Retail Pharmacy	
C. ADDO	

2. Reason for submitting this application (tick appropriate option)

A new Facility in the Fund	
Adding/Changing a new business location	
Reaccreditation	
Reinstatement	
Changing Accreditation information other than your current status following Re categorization done by the Pharmacy Council.	
Other (specify)	

3. Authority responsible for establishing/ running the facility (tick appropriate option)

1.	Public Facilities	
2.	Parastatal Facilities	
3.	NGO Facilities	
4.	FBO Facilities	
5.	Military Facilities (TPDF/JKT,POLICE ,PRISONS,TIS, IMMIGRATION,FIRE&RESCURE)	
6.	Private Facilities	
7.	Other Facilities (specify)	

4. HEALTH FACILITY INFORMATION

A. BUSINESS LOCATION INFORMATION

- Health provider must complete and submit a separate application to register each physical location (i.e., premise or other retail establishment) used to provide Medical services covered to NHIF beneficiaries,
- The address must be a specific street/Village address as recorded by the Postal Office. Give the name and address of the hospital or facility,
- A change to the business location address requires submission of professional and business licenses for the new address as per the Pharmacy Act Part IV.

If you are reporting a change of information to your current business location, check the box below and give the effective date.

Change effective Date (*mm/dd/yyyy):* _____

Change Business Location Name/Doing Business As Name
Change location from……..to……
Business Location Address Line 1 *(Street Name and Number)*

Business Location Address Line 2 *(Suite, Room, Apt. #, etc.)*		
City/Town/District	Region	
Division	Ward	
Street	Village	
Payee detail (Bank details of the business)		
Telephone Number	Fax Number (if applicable)	E-mail Address (if applicable)
Date this Business Started at this Location *(mm/dd/yyyy)*	Date this Business Terminated at this Location *(if applicable) (mm/dd/yyyy)*	

B. HOURS OF OPERATION

List your ***posted*** hours of operation as displayed at the business location in Section 2A above. If you are reporting a change to your hours of operation, check the box below and provide the effective date.

Change effective Date *(mm/dd/yyyy)*:

You must list all hours of each day you are open to the public.
Check and/or complete all boxes and/or sections for each day as appropriate. Open

24/7 (Open 24 hours a day)	
7 days a week	
6 days a week	
By Appointment Only	

Day of week	**Hours (indicate a.m. or p.m.)**		**Hours (indicate a.m. or p.m.)**		**Total hours open to the public each Day**
	Open	Close	Open	Close	
Sunday					

Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Total hours open to the public weekly					

C. Business structure information

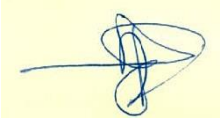
Identify the type of business structure for this Health Facility (Tick one):

Government Owned	
Parastatal organization for profit	
Parastatal organization for nonprofit	
Faith Based Organization(FBO) for profit	
Faith Based Organization(FBO) for nonprofit	
NGO for profit	
NGO for nonprofit	
Private Organization for profit	
Private Organization for nonprofit	
Limited Liability Company (LLC)	
Partnership -general	
Partnership -limited	
Sole Proprietor/Sole Proprietorship	
Other (Specify)	

6. DISTANCE TO THE NEAREST NHIF ACCREDITED HEALTH FACILITY

	Name	**Distance in Km**	**Owner**
Hospital			
H/Center			
Dispensary			
Clinic			





Diagnostic Centre			
Pharmacy			
ADDO			

7. Service offered

Type of Service	**YES**	**NO**
Medicines and Consumables		
Orthopaedic appliances		
• Others-Specify		

8. Staffing

Staff	**NO**	**NUMBER EMPLOYED**	
		Full Time	**Part time**
Full registered Pharmacist			
Pharmaceutical Technician(Diploma holder)			
Pharmaceutical Assistant(Certificate)			
Pharmaceutical dispenser (Certificate holder)			
Clinical Officer			
Nursing Officer (Degree holder)			
Assistant Nursing Officer(Diploma holder)			
Nurses			
Medical Attendance(Certificate holder)			
Optometrists			
Medical Recorder			
Other(specify)			

9. Premises infrastructure

Types of premises	**Number of rooms**
Reception	

Office of officer in in-charge	
Secretary office of officer in-charge	
Counseling room	
Refrigerator	
AC/Fan	
Dispensing room	
Store	
Dangerous Drug Cabinet	
Toilet facilities	
Washing slab	
Records	
Other (specify)	

10. Building(s)

SN	Items	
1	Wall intact/have cracks	
2	Paint: Good	
3	Ceiling: Good/Falling or leaky	
4	Doors and window: intact/broken	
5	Space in each room :adequate/inadequate	
6	Ventilation (AC Fan etc)	
7	Adequate parking space	
8	Communication	
9	Lighting	
10	Floor	
11	Waste disposal	
12	Fire safety	

11. Water Supply



Source of water:

None	
Piped	
Well	
Rain water tank	
Stream	
Is water adequate for all purposes	
Water available for drink None	
Water available for drink not boiled	

12. Sanitation (Tick where appropriate) :

SN		
	Flush toilet Pit latrine	
	Patient toilet	
	Staff toilet	
	Functional Sewerage	

13. Waste Disposal (Circle where appropriate)

- Surroundings: clean/dirty
- Waste basket/dust bin: none/present
- Dumping site: none/dirty/cared for and clean

14. Declaration

I declare that all the information in this form is correct.

Applicant Name:_____

Signature:_____ Date:_____

Authorized stamp of the facility: _____



15. FOR OFFICIAL USE ONLY

The application form has been received by NHIF office.

NHIF application fee Receipt No. _____

Name of NHIF officer receiving the application: _____

Signature: _____Date:_____

Recommendation by the Regional Manager: _____

Signature: _____ Date: _____