THE NATIONAL HEALTH INSURANCE FUND (NHIF)

APPLICATION FOR ACCREDITATION OF A HEALTH FACILITY (FOR TANZANIA MAINLAND)

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)

1. **Facility Name ____**
2. **Registration number by the Ministry of Health______________________**
3. **Business account name of the facility (Payee details)________________**

Type or level of Health Facility (tick appropriate option).

1.	National Super-Specialty Referral Hospital	
2.	Zonal Super-Specialty Referral Hospital	
3.	Regional Referral Hospital	
4.	Council Hospital	
5.	Health Center	
6.	Dispensary	
7.	Specialized Clinic	
8.	Stand Alone Diagnostic center	

4. **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 Ministry of Health.	
Other (specify)	

5. 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	
6.	Private Facilities	
7.	Other Facilities (specify)	

6. 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.

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
	Open	Close	Open	Close	

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

4. DISTANCE TO THE NEAREST NHIF ACCREDITED HEALTH FACILITY

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

5. Service offered (Where applicable)

Type of Service	**YES**	**NO**
Outpatient services		
Maternal and Child health services		
Laboratory (Category/Class)		
Dental		
Observation services(State number of beds)		
Inpatient services (State number of beds)		
Maternity services (State number of beds)		
Minor surgeries		
Major surgeries		
X-ray		

Ultrasound		
Home visiting		
Specialist Clinics		
• Medical		
• Pediatrics		
• Surgical-General		
• Orthopedics/Trauma/ Neurosurgeon		
• Obstetrics/Gynecology		
• Ophthalmology		
• Ear, Nose and Throat		
• Others-Specify		

6. Staffing

Staff	**NO**	**NUMBER EMPLOYED**	
		Full Time	**Part time**
Physicians			
Paediatricians			
Psychiatricians			
Neurophysician			
General Surgeons			
Orthopedic Surgeons			
Obstetricians & Gynecologists			
Ophthalmologists			
Ear, Nose and Throat Surgeons			
Radiologists			
Anesthesiologists			
Hematologists			
Cardiologists			
Nephrologists			

Urologists			
Endocrinologists			
Dermatologists			
Neurosurgeons			
Microbiologists			
Pathologists			
Immunologists			
Public Health			
Oncologists			
Maxillofacial Surgeon			
Other specialists (specify)			
Medical officer			
Assistant Medical Officer			
Clinical officer			
Clinical Assistant(Rural Medical Aid)			
Dentist(DDS)			
Assistant Dental officer			
Dental therapist(Dental Assistant)			
Nursing Officer (Degree holder)			
Assistant Nursing Officer(Diploma holder)			
Nurses			
Medical Attendance(Certificate holder)			
Pharmacist			
Pharmaceutical Technician(Diploma holder)			
Pharmaceutical Assistant(Certificate)			
Pharmaceutical dispenser (Certificate holder)			
Laboratory Technologist (Degree)			
Laboratory Technician (Diploma holder)			
Laboratory assistant(Certificate holder)			

Radiographer (Diploma holder)			
Radiog. Assistants (Certificate holder)			
Physiotherapists			
Optometrists			
Medical Recorder			
Other(specify)			

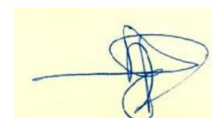
7. Premises

Types of premises	**Number of rooms**
Reception	
Office of officer in in-charge	
Secretary office of officer in-charge	
Consultation room	
Laboratory reception	
Laboratory working room	
Blood Bank	
Male Nurses changing room	
Female Nurses changing room	
Male doctors changing room	
Female doctors changing room	
Injection room	
Dispensing room	
Observation room	
Dental room	
Dressing room	
Store	
MCH rooms	
Minor Theatre	

Major Operating room	
ICU	
HDU	
Laundry	
Mortuary	
Library	
Seminars/Conference room	
Kitchen	
Toilet facilities	
Washing slab	
Incinerator	
Records	
Other (specify)	

8. Number of Beds by Type of ward

Type of ward	**Number of Beds**
Male General(Medical & Surgical)	
Female General(Medical & Surgical)	
Male Surgical	
Female Surgical	
Male Medical	
Female Medical	
Obstetric ward	
Gynecological ward	
Delivery room	
Psychiatric ward	



Pediatrics ward	
Pediatric Surgical ward	
Orthopedic ward	
Intensive care Unit (ICU)	
High Dependency Unit (HDU)	
Dental ward	
Ophthalmology ward	
E.N.T. ward	
Other specify	

9. Water Supply (Tick where appropriate)

Source of water:

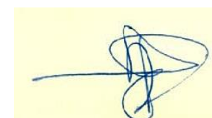
None	
Piped	
Well	
Rain water tank	
Stream	
Is water adequate for all purposes	
Water available for drink None	
Water available for drink not boiled	

10. Sanitation (Tick where appropriate):

SN	Flush toilet Pit latrine	
	Patient toilet	
	Staff toilet	
	Functional Sewerage	

11. Waste Disposal (Circle where appropriate)

- Surroundings: clean/dirty



- Waste basket/dust bin: none/present
- Dumping site: none/dirty/cared for and clean
- Incinerator: none/Not functioning/Functioning.

12. Declaration

The application form has been received by NHIF office.

NHIF application fee Receipt No: ____

Name of NHIF officer receiving the application: ___________________________

Signature: ________________________ Date: _____________________________

Recommendations by the Regional Manager: ______________________________

Signature: _____________________________ Date: _________________________