**CHECKLIST OF REQUIREMENTS FOR HOSPITAL ACCREDITATION**  
*(SECONDARY)*

**NAME OF HOSPITAL:**____________________________________________________________

**ADDRESS:** ___________________________________________________________________

1. PhilHealth application form properly accomplished.
2. Duly notarized Warranties of Accreditation.
5. List of functional / serviceable equipment signed by Medical Director / Administrator (Annex A).
   a.) Laboratory License
   b.) X-ray License
   c.) Hospital Pharmacy License
9. Complete / departmentalized list of hospital staff with respective designation indicating position as full time or part time and training if there are any (Annex D).
11. Accreditation fee of **P2,000.00** for Secondary Hospitals by postal money order payable to Philippine Health Insurance Corporation or cash paid directly to cashier and / or photocopy of OR from PRO.
12. Therapeutics Committee members and activities.
14. Photocopy of Remittance Form I (RF1) for the last quarter.
15. Sanitary permit of Dietary Section for the year 2002.

**Additional Requirements for Initial Accreditation:**

   2. Current photograph of complete hospital staff.
   3. Current standard operating procedures.
   4. SEC License / DTI certificate / CDA certificate.
   5. DOH licenses of three (3) previous successive years or Mayor’s Permit.

**DOCUMENTS SUBMITTED TO PRO:**

Region: ___________________________  Date Received: ______________________
Date Received: _____________________                  Received By: ________________________
Received By: _______________________                Received and Assessed By: ____________
Date Refiled: _______________________  

**PRO staff are advised to strictly indicate the above data.**
THE PRESIDENT
Philippine Health Insurance Corporation
Pasig City, Philippines

SIR:

I, _______________________________, Filipino of legal age, ________ with address
(Position / Designation)
at ______________________________ and the duly authorized representative to act for and in
behalf of ______________________________, hereby applies for accreditation under
(Health Care Institution)

Sec. 16 L of R.A. 7875 and its Implementing Rules and Regulations thereto. For this purpose, I hereby
submit the following pertinent information and documentary requirements.

PART I - GENERAL INFORMATION

Name of Hospital : _______________________________________________________________________
Complete Address : __________________________________________ Postal Code : ____________
PhilHealth Code No. : ___________ Tel No.: __________ Fax No.: _______________
Date established : ______________________ Date of Last Accreditation : ______________________
Chief / Medical Director : __________________________ Administrator : ______________________
DOH License No. ____________ valid from __________ to __________ issued on __________, 20___

Ownership / Management
( ) Single Proprietorship ( ) Cooperative
( ) Corporation ( ) Foundation
( ) National Government ( ) Local Government

Others, specify ________________________________

A. PHYSICAL PLANT & ENVIRONMENT

1. Building
   ( ) Concrete ( ) Old structure
   ( ) Semi-concrete ( ) Renovated
   ( ) Wood ( ) New structure

2. Sanitation and Safety Standard
   a. Water supply __________________________
   b. Electric Power _________________________
      Stand by generator ( ) Yes ( ) No
   c. Sewage Disposal _______________________
      Solid waste by ________________________
**Liquid waste by** ________________________________

**Pathological waste by** ________________________________

d. Fire escape ( ) Yes ( ) No

e. Fire extinguisher ( ) Yes ( ) No

f. Toilet facilities ( ) Yes ( ) No

3. Has there been any change in ownership or management?
   ( ) Yes ( ) No If yes, when? ______________________________

4. Has the Health Care Institution transferred to another location?
   ( ) Yes ( ) No If yes, where? ______________________________

   ( complete address )

5. Has there been any change in category or authorized bed capacity since last accreditation?
   ( ) Yes ( ) No If yes, when? ______________________________ What? ____________

B. **HOSPITAL BEDS** Submit complete list of hospital's bed per room and current rates.
   ( See Annex B )

C. **MANPOWER COMPLEMENT** ( Indicate the Number )

1. Medical Service
   a. Consultants:
      
      | Full Time | Part Time | Visiting |
      |-----------|-----------|----------|
      | General Surgery |     |     |     |
      | Sub-surgical Specialty |     |     |     |
      | OB-Gyn |     |     |     |
      | Pediatrics |     |     |     |
      | Internal Medicine |     |     |     |
      | Pathology |     |     |     |
      | Radiology |     |     |     |
      | Dental |     |     |     |
      | Others |     |     |     |

   b. Residents
      
      |          |     |     |     |

2. Nursing Service
   a. Registered Nurse
   b. Registered Midwives
   c. Nursing Aides

3. Pharmacist

4. Laboratory & X-ray
   a. Medical Technologist
   b. X-ray Technologist

5. Dentist
6. Dietitian
7. Administrative Service
8. Others

NOTE : Submit complete list of hospital personnel. ( See Annex D )

D. **CLINICAL FACILITIES**

   ( ) Emergency room
   ( ) Doctor's / Consultation office
   ( ) Clinical laboratory
      Laboratory Lic. No. __________ valid from __________ to __________
   ( ) X-ray facility
      X-ray Lic. No. __________ valid from __________ to __________
( ) Pharmacy Lic. No. __________ valid from __________ to _____________
( ) Dental room
( ) Drug room
( ) Labor room
( ) Delivery room
( ) Nursery room: No. of Bassinet / s ______ No. of Incubator / s ______
( ) Operating room: Minor OR ______ Major OR ______
( ) Recovery room
( ) Medical Records room
( ) Dietary room
( ) Others, please specify ____________________________________________

E. EQUIPMENT Submit complete list of existing functional or serviceable equipment under each facility. (Please see Annex A)

F. CLINICAL SERVICE

( ) General Medicine ( ) Anesthesia
( ) General Surgery ( ) OB-Gyn
( ) Orthopedic Surgery ( ) Pediatrics
( ) Ophthalmology ( ) Dermatology
( ) Otolaryngology ( ) Others, specify ______________

G. RECORDS

( ) Admission & discharge records
[ ] Prescribed logbook (Follow PhilHealth Cir. No. 56 s.1999, No. 38 s.2000 & No. 7 s.2002)

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Admission Date &amp; Time</th>
<th>Name of Patient</th>
<th>Age</th>
<th>Sex</th>
<th>Address</th>
<th>Membership</th>
<th>Admitting Diagnosis</th>
<th>Final Diagnosis</th>
<th>Attending Physician</th>
<th>Disposition</th>
<th>Disposition Date &amp; Time</th>
</tr>
</thead>
</table>

( ) Patient’s chart
( ) Laboratory logbook

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Name of Patient</th>
<th>Age</th>
<th>Sex</th>
<th>Type of Examination</th>
<th>Date of Examination</th>
</tr>
</thead>
</table>

( ) X-ray logbook

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Name of Patient</th>
<th>Age</th>
<th>Sex</th>
<th>Type of Examination</th>
<th>Date of Examination</th>
</tr>
</thead>
</table>

( ) OR logbook

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Name of Patient</th>
<th>Age</th>
<th>Sex</th>
<th>Membership</th>
<th>Admitting Diagnosis</th>
<th>Procedure Done</th>
<th>Surgeon</th>
<th>Date of Operation</th>
</tr>
</thead>
</table>

( ) OPD logbook
( ) Outpatient surgical logbook
( ) Mandatory monthly hospital reports

H. QUALITY ASSURANCE PROGRAM OF THE INSTITUTION

1. Plan
2. Mission and Vision
3. Personnel Responsible for the Program
4. Activities
5. Minutes of Meeting