CHECKLIST OF REQUIREMENTS FOR HOSPITAL ACCREDITATION
( TERTIARY )

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).
10. Accreditation fee of P3,000.00 for Tertiary Hospitals by postal money order payable to Philippine Health Insurance Corporation or cash paid directly to cashier and / or photocopy of OR from PRO.
11. Therapeutics Committee members and activities.
12. Antimicrobial resistance surveillance program, names of personnel involved or Infection Control Committee, with names of 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: TO PHILHEALTH CENTRAL OFFICE:
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.
APPLICATION FOR ACCREDITATION (TERTIARY)

SIR:

I, ________________________, Filipino of legal age, __________________________ with (Position / Designation)
address at ______________________________________________ and the duly authorized representative to act for and in behalf of _________________. (Health Care Institution)

applies for accreditation under 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 1 - 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 _________________________________________________________________

MMC/TERTIARY/050302
2. T

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? __________________________________________

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

1.1. Consultants:

<table>
<thead>
<tr>
<th>Full Time</th>
<th>Part Time</th>
<th>Visiting</th>
<th>Residents</th>
</tr>
</thead>
</table>
| a. Surgery
  - General Surgery
  - Cardio Vascular Surgery
  - Neuro Surgery
  - Orthopedic Surgery
  - Ophthalmology
  - Otolaryngology
  - Plastic Surgery
  - Surgical Oncology
  - Thoracic surgery
  - Urology |
| b. OB-Gyn |
| c. Anesthesia |
| d. Internal Medicine
  - General Medicine & Infectious Disease
  - Allergology
  - Cardiology
  - Endocrinology
  - Dermatology
  - Gastroenterology
  - Haematology
  - Nephrology
  - Neurology
  - Oncology
  - Psychiatry
  - Pulmonary
  - Rheumatology |
| e. Pediatrics
  - General Pediatrics
  - Neonatology
  - Other Pediatric Subspecialty |
| f. Pathology |
| g. Radiology |
| h. Dental Medicine |

2. Nursing Service

a. Registered Nurse
b. Registered Midwives
c. Nursing Aides
3. Pharmacist
   a. Registered Pharmacist
   b. Pharmacy Aides
4. Laboratory & X-ray
   a. Medical Technologist
   b. X-ray Technologist
5. Dietary Service
   a. Dietitian
   b. Food Servers
6. Engineering & Maintenance Service
7. Others, specify ___________________

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

D. MEDICAL FACILITIES
   ( ) Emergency room
   ( ) Out-patient department
   ( ) Clinical laboratory
   Laboratory Lic. No. ____________ valid from _____________ to _______________ 
   ( ) X-ray facility
   X-ray Lic. No. ____________ valid from _____________ to _______________ 
   ( ) Pharmacy Lic. No. ____________ valid from _____________ to _______________ 
   ( ) Labor room & Delivery room
   Nursery room: No. of Bassinet / s _________ No. of Incubator / s _________
   ( ) Operating room complex: No. of Minor OR _______ No. of Major OR _______
   ( ) ICU
   ( ) Recovery room
   ( ) Dental service
   ( ) Central stock supply
   ( ) Dietary service
   ( ) Blood bank
   ( ) Nuclear Medicine
   ( ) Cancer clinic
   ( ) Rehabilitation department
   ( ) Medical Records
   ( ) Ambulance service
   ( ) Training service
   Accredited Internship Training Program ( ) Yes ( ) No
   Residency Training Program ( ) Yes ( ) No
   College of Nursing ( ) Yes ( ) No
   School of Midwifery ( ) Yes ( ) No
   ( ) 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
   ( ) Subspecialty of Internal Medicine. Enumerate available subspecialty services:
   __________________________________________________________________________
   ( ) General Surgery
   ( ) Subspecialty of Surgery. Enumerate available subspecialty services:
   __________________________________________________________________________
   ( ) OB-Gyn
   ( ) General Pediatrics
   ( ) Subspecialty of Pediatrics. Enumerate available subspecialty services:
   __________________________________________________________________________
G. RECORDS

( ) Admission & discharge records
[ ] Prescribed logbook (Follow PhilHealth Cir. [ ] Computerized 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>

( ) OPD records
[ ] Logbook [ ] Index card [ ] Computerized

( ) 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>

( ) Major 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>

( ) DR logbook
( ) Minor surgical logbook
( ) Patient's chart
( ) 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