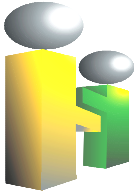


Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
ACCREDITATION DEPARTMENT
12th Floor City State Centre Bldg., 709 Shaw Blvd. Oranbo, Pasig City
Tel No. 637-62-65 Trunk line 637-99-99 loc 1215, 1216, Telefax. 637-25-27
E-mail: Accre@philhealth.gov.ph

CHECKLIST OF REQUIREMENTS FOR HOSPITAL ACCREDITATION (TERTIARY)

NAME OF HOSPITAL:____

ADDRESS: ____

_________ 1. PhilHealth application form properly accomplished.
_________ 2. Duly notarized Warranties of Accreditation.
_________ 3. DOH License issued 2002.
_________ 4. PHA / PHAP Certificate of Membership issued 2002.
_________ 5. List of functional / serviceable equipment signed by Medical Director / Administrator (Annex A).
_________ 6. List of current hospital's bed rates (Annex B).
_________ 7. List of current hospital service charges (Annex C).
_________ 8. Ancillary Licenses issued / revalidated 2001 - 2002.
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.
_________13. Ongoing Quality Assurance Program.
_________14. Photocopy of Remittance Form I (RF1) for the last quarter.
_________15. Sanitary permit of Dietary Section for the year 2002.
_________16. Updated Health Certificate of Dietary personnel.
_________17. Fire Safety Permit for 2002.

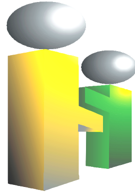
Additional Requirements for Initial Accreditation:

_________ 1. Current photographs of hospital façade, ER, Laboratory, Pharmacy, X-ray, Nursery, DR, OR, Recovery Room, ICU, Isolation Room, CR, Records, Business Office, Nurses Station, CSS and other available hospital facilities.
_________ 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: ______________________
Received By: ________________________
Date Refiled: ________________________

TO PHILHEALTH CENTRAL OFFICE:
Date Received: _______________________
Received By: __________________________
Received and Assessed By: ____________

PRO staff are advised to strictly indicate the above data.



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PhilHealth ACCREDITATION FORM **1 T**
APPLICATION FOR ACCREDITATION (TERTIARY)

_____________________, 20___

THE PRESIDENT
Philippine Health Insurance Corporation
Pasig City, Philippines

SIR :

I, ____________________________________, Filipino of legal age, ___________________________ with
(Position / Designation)

address at ____ and the duly authorized representative

to act for and in behalf of ____, hereby
(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 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 facilites** ( ) 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**

1.1. Consultants:	Full Time	Part Time	Visiting	Residents
a. Surgery	________	________	_______	________
General Surgery	________	________	_______	________
Cardio Vascular Surgery	________	________	_______	________
Neuro Surgery	________	________	_______	________
Orthopedic Surgery	________	________	_______	________
Opthalmology	________	________	_______	________
Otolaryngology	________	________	_______	________
Plastic Surgery	________	________	_______	________
Surgical Oncology	________	________	_______	________
Thoracic surgery	________	________	_______	________
Urology	________	________	_______	________
b. OB-Gyn	________	________	_______	________
c. Anesthesia	________	________	_______	________
d. Internal Medicine	________	________	_______	________
General Medicine & Infectious Disease	________	________	_______	________
Allergology	________	________	_______	________
Cardiology	________	________	_______	________
Endocrinology	________	________	_______	________
Dermatology	________	________	_______	________
Gastroentorology	________	________	_______	________
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	________	________

	Full Time	Part Time
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 <u>functional or serviceable</u> 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:
____
____

( ) Opthalmology
( ) Otolaryngology

G. RECORDS

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

Case No.	Admission Date & Time	Name of Patient	Age	Sex	Address	Membership	Admitting Diagnosis	Final Diagnosis	Attending Physician	Disposition	Disposition Date & Time

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

Case No.	Name of Patient	Age	Sex	Type of Examination	Date of Examination

( ) X-ray logbook

Case No.	Name of Patient	Age	Sex	Type of Examination	Date of Examination

( ) Major OR logbook

Case No.	Name of Patient	Age	Sex	Membership	Admitting Diagnosis	Procedure Done	Surgeon	Date of Operation

( ) 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