APPLICATION FOR CERTIFICATION

OF

Medical Laboratory

Issue No.: 03
Issue Date: May 2014

NATIONAL ACCREDITATION BOARD FOR HOSPITALS & HEALTHCARE PROVIDERS

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Assessment criteria and Fee structure

Size of Laboratory	Assessment Day(s)	Application cum Certification Fee
Micro sized Laboratory *(up to 25 Patients per day)*	Half Day	12500
Small sized Laboratory *(26 – 100 Patients per day)*	Half Day	25000
Medium sized Laboratory *(101 – 300 Patients per day)*	One Day	50000
Large sized Laboratory *(301 & above Patients per day)*	Two Days	80000

Service Tax: A service tax as applicable from time to time (currently 12.36%) will be charged on all the above fees. You are requested to please include the service tax in the fees accordingly while sending to NABH.

Guidance notes:

1. Two copies of Application Form to be submitted along with applicable fees, copy of last internal audit report and minutes of management review meeting.
2. Fees to be paid through Demand Draft/ local cheque in favour of 'Quality Council of India' payable at New Delhi.
3. The fee includes expenses on travel and lodging/ boarding of assessors.
4. The certification, once granted shall be valid for two years.
5. This certification shall be applicable only to the site where sample processing, testing and reporting of the results is being done and shall not be applicable to any collection centres attached to the laboratory.

Application Form for Certification of Medical Laboratory

1. **Name of the Laboratory:**

   ____

2. **Address:** ____

   ____

   ____

3. **Name of Parent Organization:** ____
   (Name of hospital/organization to which it is attached)

   Telephone No. ____________________ Fax No. _________________ E-mail _____________________

4. **Legal Status and date of establishment:** ___________________________________
   (Registration No. and authority who granted the registration)

   ____

5. **Contact person(s):**
   (Please indicate [√] with whom correspondence be made)

   - Chief Executive Officer: (or equivalent) ☐
     Mr. /Ms. /Dr. ____
     Designation: ____
     Tel: ____________________________ Mobile: ____________________________
     Fax: ____
     E-mail: ____

   - Certification Coordinator: ☐
     Mr. /Ms. /Dr. ____
     Designation: ____
     Tel: ____________________________ Mobile: ____________________________
     Fax: ____
     E-mail: ____

6. Size of Medical Laboratory (based on average patient load per day for last six months):

A. Micro sized Laboratory *(up to 25 Patients per day)* ☐
B. Small sized Laboratory *(26 – 100 Patients per day)* ☐
C. Medium sized Laboratory *(101 – 300 Patients per day)* ☐
D. Large sized Laboratory *(301 & above Patients per day)* ☐

7. Other Certifications/ Accreditations, if any:____________________________________

8. Scope of Certification:
(Please indicate [√] discipline applicable)

Sl.	Facility	Discipline
1.	Medical Laboratory	i. Clinical Biochemistry ii. Pathology iii. Microbiology & Serology iv. Genetics v. Nuclear Medicine (in-vitro tests only)- Requirement as laid down by Atomic Energy Regulatory Board (AERB)

9. Organization Chart: Provide organization chart with all its facilities

10. Staff Information: Details with educational qualification and experience of all working staff

Sl.	Name	Designation	Qualification	Total Years of experience	Area of Competency (Biochemistry / Pathology/ Genetics/ Microbiology /etc....)

11. **Equipment:** Details of all equipments in the Medical Laboratory

Sl.	Laboratory Equipment	Equipment ID.	Date of Installation	Model Number	Manufacturer's Name	Last Date of Calibration	Due date of Calibration	Present Working Status

12. **Proficiency Testing Programme** (Details of all proficiency testing programme that the laboratory has participated including name of programme, tests covered, frequency and results):

13. **Working Days** (Please Tick the correct box in the table below)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

14. **Is Your Lab 24 Hrs Open?**
☐ Yes
☐ No

15. **Working Hours**:

16. **Internet Access Availability:**
☐ Yes
☐ No

17. **Total floor area of the laboratory {In square feet (Ft^2) / Square metre (M^2)}:**

18. Details of Internal Audit & Management Review:

Date of last Internal Audit: ____

Date of last Management review: ____

19. Declaration by Medical Laboratory:

We hereby declare that:

We are familiar with the terms and conditions of maintaining NABH certification (NABH-T&C).

We agree to comply at all times with NABH standards for the certification of Medical Laboratory.

We agree to comply with relevant procedures, pay all costs for assessment, verification visit (if any), irrespective of the result.

We agree to co-operate with the assessment team appointed by NABH for examination of all relevant documents by them and their visits to those parts of the Medical Laboratory that are part of the scope of certification.

20. Date of completion of application: __________ Day __________ Month ________Year

____

Director/ Authorized Signatory

Name: ____________________________

Designation: ________________________

NATIONAL ACCREDITATION BOARD FOR HOSPITALS

& HEALTHCARE PROVIDERS (NABH)

Quality Council of India

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