Participation Requirements (Critical Criteria)

(Photographic/ Video evidence is necessary for the below criteria by the Assessment team)

Name of Hospital:		**Date/Time:**		
Sr.	**POINTS**	**YES**	**NO**	**REMARKS**
1.	**Hospital found Functional** (If "Yes" clear Video evidence should be provided)			
2.	**Registration with Health Care Commission as a hospital**			
3.	**Accessibility** (Yes, if below points are "Yes")			
	a) Motorable road			
	b) Ramp or functional bed Elevator 24 hr.'s Service *(elevator having Generator Support)*			
4.	**24/7 Emergency Services available** (Yes, if below points are "Yes")			
	a) On Duty Medical Officer available			
5.	**Emergency Services at Ground Floor**			
6.	**Availability of in-house Pharmacy** (if "Yes" these drugs shall be available at the stock e.g., adrenaline, atropine, calcium gluconate, magnesium sulfate, Solu cortef, avil, Decadron, salbutamol, aminophylline, haemacel)			
7.	**Availability of in-house Laboratory** (if "Yes Baseline investigations shall be available e.g., CBC, RFTS, electrolytes, Urine R/E, FBS, RBS, ESR, HBS/HCV, BT & CT)			
8.	**At least 3 Specialties available (Except Category D Districts)**			
	Consultants Clinics available as evidence & Admission record			
	a) General Surgery & Allied Surgery (Eye, ENT, Ortho Urology. Etc.)			
	b) Gynecology (Yes, if below point are "Yes")			
	i)Functional labor room			
	ii)WMO Available			
	iii)Gynecologist available (On call)			
	c) Medicine & Allied			
9.	**Availability of Operation Theatre (OT)**			
	a) Anesthesia machine available			
	b) Is OT Functional			
	(Mark "yes" if OT record is provided)			
10.	**Expired Medication/Disposables** (Evidence should be collected along with Expiry form duly Signed and Stamped by the hospital)			
	a) In the Shelf's of non-expiry medicines at Pharmacy			
	b) Operation theater (OT)			
	c) ICU/CCU/NICU			
	d) Emergency Room			
	e) Labor Room			
11.	The hospital is having _____Number of hospital specific functional Beds available. (The total beds number of below departments be mentioned in the blank (Mark "Yes" if the hospital qualifies the prescribed number of beds approved for the district by the Government of KP)			
	a. Emergency Room Beds _____			
	b. Wards Beds _____			
	c. ICU/CCU Beds _____			

Note: Hospital Must provide documentary evidence for all above qualifying points.

I, the undersigned, confirm and agree with the hospital assessment process and evaluation

Hospital Stamp and Signature:

Assessment Done By:

_____

Hospital's Focal Person Name

_____

Name