Category (III) Hospitals, Maternity, and Nursing Homes in category E and below of the N.H.I.F. Scheme.

Category (IV) Polyclinics, laboratories, radiology premises and other specialized clinics.

Category (V) Mission Hospitals.

Category (VI) Institutional clinics and dispensaries.

Made on the 17th February, 2000.

AMUKOWA ANANGWE,
Minister for Medical Services.

LEGAL NOTICE NO. 26

THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(*Cap.* 253)

IN EXERCISE of the powers conferred by section 23 of the Medical Practioners and Dentists Act, the Minister for Medical Services after consultation with the Board, makes the following Rules:—

THE MEDICAL PRACTITIONERS AND DENTISTS (FORMS AND FEES (AMENDMENT) RULES, 2000

1. These Rules may be cited as the Medical Practitioners and Dentists (Forms and Fees) (Amendment) Rules, 2000.

Sub. Leg.

2. The Medical Practitioners and Dentists (Forms and Fees) Rules are amended—

(a) by inserting the following new Rules immediately after rule 10—

11. Application for registration of a private medical institution in accordance with rule 4 (1) of the Medical Practitioners and Dentists (Private Medical Institutions) Rules shall be in Form IX set out in the First Schedule to these Rules.

12. The certificate of registration to be issued by the Registrar in accordance with rule 4 (3) of the Medical Practitioners and Dentists (Private Medical Institutions) Rules shall be in Form X set out in the First Schedule to these Rules.

13. Application for a licence to operate an approved private medical institution in accordance with rule 5 (1) of the Medical Practitioners and Dentists (Private Medical Institutions) Rules shall be in Form XI set out in the First Schedule to these Rules.

14. The annual fees assessment form prescribed in rule 5 (3) of the Medical Practitioners and Dentists (Private Medical Institutions) Rules shall be in Form XII set out in the First Schedule to these Rules.

15. A licence issued to operate an approved private medical institution in accordance with Rule 5 (4) of the Medical Practitioners and Dentists (Private Medical Institutions) Rules shall be in Form XIII set out in the First Schedule to these Rules.

(b) by inserting the following new Forms IX to XIII immediately after Form VIII in the First Schedule:

ORIGINAL

FORM IX

(r. 4 (1))

Serial No. .....

THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(*Cap.* 253)

APPLICATION FOR REGISTRATION OF A PRIVATE MEDICAL INSTITUTION

PART I

(To be completed by the applicant in triplicate)

1. Name and Address of the Proposed Institution (Block Letters) .....

.....

.....

.....

2. Type (State whether Hospital, Nursing Home, Maternity Home, Health Centre, Dispensary, Laboratory, etc. .....

.....

.....

3. Location of the Institution:

(a) Town/Centre/Market* .....

(b) Location .....

(c) District .....

(d) Province .....

*Delete where inapplicable.

Part II

(To be completed by the applicant in triplicate)

1. Full Name and Address of the Applicant (Block Letters) .....

.....

.....

2. State if Applicant is a Director and/or Administrator of the Institution .....

.....

.....

3. Nationality of the Applicant .....

4. Place and Date of Birth .....

5. Kenya National Identity Card No. .....
(Attach photocopy

6. Passport No. (if applicable) .....

.....

7. Work Permit No. (if applicable) .....
(Attach documentary evidence—copies only).

PART III

(To be completed by the applicant in triplicate)

Give full names of Directors of the Institution including the following: Nationalities, Passport Numbers, Work Permit Numbers, Kenya National Identity Card Numbers, etc.

(Attach copies of documentary evidence)

(a) .....

.....

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(b) .....

.....

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(c) .....

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(Use extra space if necessary)

PART IV

(To be completed by the applicant in triplicate)

1. Give full names of Medical or Dental Practitioner who shall be in-charge of patient health care at the proposed institution .....

.....

.....

.....

.....

2. *(a)* Give full details of professional qualifications of the person named in paragraph (1) above. Include year and place where obtained.

(b) State work experience of the person named in paragraph (1) above and name institutions where obtained and date.

(c) Attach copies of documentary evidence in each case. (Use extra space if necessary)

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3. *(a)* Give full names and professional qualifications of any other person(s), identified by your institution, to undertake patient health care at the institution (e.g. Clinical Officers, Nurses, Laboratory Technicians, X-ray staff, Doctors, Technicians, Pharmaceutical Technologists, etc.).

(b) Attach copies of documentary evidence in each case. (Use extra space if necessary.

(i) .....

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(ii) .....

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(iii) .....

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(iv) .....

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(v) .....

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(vi) .....

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PART V

(To be completed by the Medical Officer of Health in triplicate)

INSPECTION REPORT FOR PRIVATE MEDICAL INSTITUTION FOR REGISTRATION PURPOSES

1. Name of Institution .....

.....

2. Physical Location:

(a) Plot No./L.R. No. .....

(b) Market/Centre/Town* .....

(c) Street/Road* .....

(d) Division .....

(e) District .....

(f) Province .....

*Delete where inapplicable.

3. Premises General Information:

(a) Plot area (in hectares) .....

(b) Water supply ..... adequate/inadequate*

(c) Refuse Disposal:

(i) Incenerator available/Not available*.

(ii) Other modes of refuse disposal.
(Specify)

.....

.....

(d) Environmental suitability .....
recommended/not recommended.* State reasons for not recommending.

.....

.....

.....

.....

.....

4. Plan of the Institution:

(a) Approved/Not approved* by the local District Development Committee (attach copy of the plan) and documentary evidence (copies) of approval of the institution by the D.D.C.

5. Out-patient Services:
(See attached minimum requirements for General Practice).

(a) Waiting Bay/Reception Area/Room:*

(i) Seating capacity .....

(ii) Area (in square metres) .....

(iii) Construction ..... covered/not covered*.

(b) Examination Rooms:

(i) Number of rooms .....

(ii) State if equipment inspected meets the minimum requirements.
(Attach separate signed list of equipment inspected if necessary).

---

*Delete where inapplicable.

.....

.....

.....

.....

(c) Treatment rooms:

(i) Number of rooms .....

(ii) State if equipment meets the minimum requirements. (Attach separate signed list of equipment inspected).

6. In-patient Services:

(a) Female Ward:

(i) Size of ward (in square metres) .....

(ii) Number of beds .....

(iii) Number of toilets .....

(iv) Number of bathrooms .....

(v) Number of sluice rooms .....

(b) Male Ward:

(i) Size of ward (in square metres) .....

(ii) Number of beds .....

(iii) Number of toilets .....

(iv) Number of bathrooms .....

(v) Number of sluice rooms .....

(c) Maternity Ward:

(i) Size of Ward (in square metres) .....

(ii) Number of beds .....

(iii) Number of toilets .....

(iv) Number of bathrooms .....

(v) Number of sluice rooms .....

(vi) Placenta pit depth (in square metres) .....

(c) Paediatric Ward:

(i) Size of Ward (in square metres) .....

(ii) Number of beds .....

(iii) Number of bathrooms .....

(vi) Number of sluice rooms .....

7. Clinic Support Services:

(a) Pharmacy:

(i) Area of waiting room (in square metres) .....

(ii) Number of dispensing windows .....

(iii) Number of anti-biotic (safe cupboards) .....

(iv) Number of drug stores .....

(b) Laboratory:
(See attached minimum requirements).

(i) Reception area (in square metres) .....

(ii) Seating capacity .....

(iii) Size of work-room (in square metres) .....

(iv) Equipment (Attach a separate signed list of equipment and reagents/ chemicals inspected).

(c) X-Ray Unit:
(See attached minimum requirements)

(i) Size of reception area (in square metres) .....

(ii) Seating capacity .....

(iii) Number of screening rooms .....

(iv) Standard of radiation protection .....
Adequate/Not Adequate*.

(v) Equipment (Attach separate signed list of equipment inspected).

d) Operating Theatre:

(i) Minor theatre equipment (Attach a separate signed list of equipment inspected)

(ii) Major theatre (indicate by a tick or cross in the box next to the item to show whether available or not available).

Induction room ☐

Operating room ☐

*Delete where inapplicable.

Recovery room ☐

Lighting ..... Adequate/Not Adequate*.

Equipment ..... (attach separate signed list of equipment inspected).

8. Other Supporting Services:

(a) Kitchen:

(i) Cooking facility (specify) .....

(ii) Non-perishable store ..... Available/Not Available*.

(iii) Perishable store ..... Available/Not Available*.

(b) Laundry type (specify) .....

(c) Mortuary:

(i) Available/Not Available*.

(ii) Refrigerated/Not refrigerated*.

(iii) Appropriately located/Not appropriately located*.

If not appropriately located state why .....

.....

(iv) Body capacity .....

(v) Adequate Privacy/Not Adequate Privacy* .....

(vi) Number of ambulances .....

(vii) Other facility (specify and use extra space if necessary) .....

*Delete where inapplicable.

PART VI

(To be completed by the Medical Officer of Health in triplicate)

1. Give full names and designations of members of the D.H.M.T. who participated in the inspection of the institution.

Name	*Designation*
(i)	.....

(ii) ....

(iii) ....

(iv) ....

(v) ....

(vi) ....

(vii) ....

(viii) ....

(ix) ....

(x) ....

2. Certificate by M.O.H.

I, Dr. .....
(State full names in Block Letters)

being the Medical Officer of Health in-charge ..... District, do hereby certify that the inspection of .....

was conducted by the District Health Management Team of .....

on the ..... day of ..... , 20 ..... under my personal supervision.

I further certify that the inspection was witnessed by Dr./Mr./Mrs./Miss .....

.....

being the Owner/Director/Applicant* and that ..... the said institution does/does not* meet the minimum requirements for Registration/Licensing purposes.

Dated this ..... day of ....., 20 .....

Signature .....
(Medical Officer of Health)

Name of Station .....

Address .....

.....

Telephone Number .....

*Delete where inapplicable.

PART VII

(To be completed by the Applicant/Director/Owner of the institution in triplicate)

I, Dr./Mr./Mrs./Miss* .....

(Full Names in Block Letters)

hereby certify that all information given by me in this application form is true and correct and that I personally witnessed the inspection which was conducted by the Medical Officer of Health on the ..... day of ....., 20 .....

Signature .....

Names in Full .....

Applicant to Note:

This application form must be returned to the Medical Practitioners and Dentists Board within a period not exceeding three months from the date of issue.

Applications which are not returned within the stipulated period shall be time barred.

PART VIII

(For the purposes of vetting applications and enforcement of Laws, Regulations and Decisions of the I.R.C. and the Board)

(a) Name of institution acceptable to the I.R.C. .....

(b) Type of institution .....

(c) Give Names, Types, Locations and Registration Numbers of other institutions operated by the Applicant/Director or affiliated to the institution named in this application.

(i) .....

.....

(ii) .....

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(iii) .....

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(iv) .....

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(v) .....

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(Use extra space if necessary)

(d) **Give full particulars of criminal court proceedings for violations of any of the following Ministry of Health laws by any of the Institutions named in paragraph *(c)*:**

Caps. 253, 260, 244, 245, 254, and 242 (quote court case references in each case for the past three years proceeding the date of this applications.

.....

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(Use extra space if necessary).

(e) **Give names of institutions, their location and registration numbers from among those named in paragraph *(c)* which have defaulted in licence fees payment during the past three years. State each year of default and penalty imposed and whether or not penalty has been paid and fees recovered:**

.....

.....

.....

.....

(f) **Give names of any of the institutions named in paragraph *(c)* which the Board has authorized closure during the past three years (quote minutes references of the I.R.C. and state the institutions' Registration Numbers and place of location).**

.....

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(Use extra space if necessary).

(g) F.R.L. Serial No. and date of this application .....

(h) Licence Fees Category (Quote I.R.C. minutes reference) .....

(i) F.R.L. Receipt No. and Date .....

(j) Date application returned to applicant .....

(k) Date application re-submitted by applicant .....

(l) Registration fees Receipt No. and Date .....

CERTIFICATE BY AN OFFICER AUTHORIZED FOR THE PURPOSES OF PART VII OF THIS APPLICATION

(This certificate must be countersigned by the Registrar)

I, certify that the institution for which this application is made and it's Owner/Director/Applicant or it's Administrator has/has not* been subject of criminal court proceedings in violation of any of the laws named in Part VIII *(d)* in this application and that all information given under Part VIII of this application is correct and true.

Dated this ..... day of ....., 20 .....

.....

Authorized Officer *Registrar, M.P. and D.B./D.M.S.*

PART IX

FOR OFFICIAL USE ONLY

1. *Institution*	*Registration*	*Committee*	*Recommendation*
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

*Delete where inapplicable.

.....

.....

.....

.....

Dated this ..... **day of** ....., **20** .....

.....
Chairman,
Medical Practitioners and Dentists Board

.....
Chairman, Committee

INSTRUCTIONS TO THE REGISTRAR BY THE BOARD

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Dated this ..... **day of** ....., **20** .....

.....
Chairman,
Medical Practitioners and Dentists Board.

(r. 4 (3))

Serial No. .....

FORM X

THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(*Cap.* 253)

CERTIFICATE OF REGISTRATION AS A PRIVATE MEDICAL INSTITUTION

1. Name of Institution .....

.....

P.O. Box .....

.....

2. Type .....

.....

.....

has been registered as a Private Medical Institution in accordance with rule 4 (3) of the Medical Practitioners and Dentists (Private Medical Institutions) Rules.

Date .....

SEAL OF THE BOARD

....

CHAIRMAN M.P. & D. BOARD *REGISTRAR M.P. & D. BOARD/DMS*

(a) It shall be the duty of the holder of this certificate to inform the Registrar within fourteen (14) days of any change in the registered address in accordance with section 5 of the Medical Practitioners and Dentists (Private Medical Institutions) Rules.

(r. 5 (1))

Serial No. .....

FORM XI

THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(*Cap.* 253)

APPLICATION FOR LICENCE OR RENEWAL OF LICENCE TO OPERATE A PRIVATE MEDICAL INSTITUTION

PART A

(to be completed by the applicant in triplicate)

1. **Full Name and Address of Institution** .....

.....

.....

2. **Registration Number and Date of Registration** .....

.....

.....

3. **Previous Licence Number and Year Issued** .....

.....

.....

4. **Type of Institution** .....

.....

5. **Previous Licensing Category and Number of Annual Fees Assessment Form** .....

.....

.....

6. **Physical Location of Institution** .....

.....

7. **Specify Whether this is a New Application or a Renewal** .....

.....

8. **N.H.I.F. Category** .....

Signature of Applicant .....

Date .....

(r. 5 (3))

Serial No. .....

FORM XII

THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(*Cap.* 253)

ANNUAL FEES ASSESSMENT FORM

PART A

(to be completed in triplicate)

1. Name of Institution .....

.....

2. Registration Number and Date .....

.....

3. Physical Location .....

4. Name and Address of Applicant for Licence .....

.....

.....

.....

5. Fees Category for Year .....

(I) ☐

(II) ☐

(III) ☐

(IV) ☐

(V) ☐

(tick relevant box)

6. Fees Rates Applicable to Institution .....

Licence fees (amount in words) .....

.....

PART B

(to be completed by M.O.H. in triplicate)

CERTIFICATE BY MEDICAL OFFICER OF HEALTH

I, Dr. (Full Names in Block Letters) .....

Being the Medical Officer of Health in-Charge .....

.....

District of .....

Province do hereby certify that the institution named in this application form was last inspected on ..... day of ....., 20 ..... and in my opinion the current condition of its premises requires/does not *require fresh inspection.

(*delete where inaplicable)

Dated this ..... day of ....., 20 .....

OFFICIAL SEAL

.....

MEDICAL OFFICER OF HEALTH

STATION .....

ADDRESS .....

TELEPHONE .....

(a) Plot No. .....

(b) Town/Market* .....

(c) Street/Road* .....

(d) Location .....

(e) Division .....

(f) District .....

(g) Province .....

7. Date of last inspection of the Institution by the Ministry of Health .....

.....

*Delete where inapplicable.

PART C

(to be completed by the applicant in triplicate)

CERTIFICATE BY THE APPLICANT

I, Dr./Mr./Mrs./Miss (Full Names in Block Letters) .....

.....

of P.O. Box .....

being the Administrator/Owner/Director* (Specify other) .....

.....

of (give full names of the institution) .....

.....

.....

.....

do hereby certify that the information given by me in this application is true and correct.

Dated this ..... day of ....., 20 .....

(*delete where inapplicable)

.....

APPLICANT

PART D

(FOR OFFICIAL USE ONLY)

(a) Acceptable name of institution and type .....

.....

.....

.....

(b) FRL Serial Number and Date .....

.....

(c) Registration Certificate Number and Date .....

.....

(d) Licence Fees Assessment Number and Date .....

.....

(e) **Category of Licensing** .....

.....

(f) **Registration Fees Receipt Number and Date** .....

.....

(g) **Date application sent to IRC/Board** .....

.....

(h) **Remarks** .....

.....

.....

I certify that I have personally checked the information above and found it correct and that all procedures and documentation pertaining to this application have been complied with.

Dated this ..... **day of** ....., **20** .....

.....

REGISTRAR M.P. & D.B./DIRECTOR OF MEDICAL SERVICES

(r. 5 (4))

Serial No. .....

FORM XIII

THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(*Cap.* 253)

LICENCE No. .....

LICENCE TO OPERATE A PRIVATE MEDICAL INSTITUTION

1. **Name of Institution** .....
(Full Names in Block Letters)

of P.O. Box .....

(full address) is hereby licensed to operate a Private Medical Institution in accordance with the provisions of rule 5 (4) of the Medical Practitioners and Dentists (Private Medical Institutions) Rules.

2. **This licence entitles the Private Medical Institution to operate as** .....

.....

3. **Authorized Premises for the Institution** .....

.....

4. **Maximum Number of Patients** .....

5. **This Licence shall expire on the last day of** ..... , 20.....

6. **No change of premises is permitted without the authority of the Board.**

Dated this ..... **day of** ....., 20 .....

.....

Registrar

MEDICAL PRACTITIONERS AND DENTISTS BOARD/DIRECTOR OF MEDICAL SERVICES

CONDITIONS OF LICENCE

This licence issued on condition that minimum requirements set by the Board for operation of the Private Medical Institutions are adhered to at all times.

(c) **by inserting the following new fees in the Second Schedule—**

FEES PAYABLE UNDER THE PRIVATE MEDICAL INSTITUTIONS RULES

Category	*Application fee*	*Registration fee*	*Annual licence fee*
			KSh.
I	1,000	50,000	100,000
II	1,000	20,000	50,000
III	1,000	15,000	30,000
IV	1,000	10,000	20,000
V	1,000	5,000	10,000
VI	1,000	5,000	10,000

Dated the 17th February, 2000.

AMUKOWA ANANGWE,
Minister for Medical Services.

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