**Application for MBFHI Certification of health care institution**

From

To,

State mission Director,

Chair person .MBFHI state committee

SPMSU,NHM Kerala

DHS Compound, General hospital junction

Thiruvananthapuram, Kerala

695035

**REQUEST FOR ASSESSMENT OF HEALTH FACILITY FOR MBFHI CERTIFICATION**

Sir,

We are happy to inform that MBFHIProgrammeat our Health facility as per the MBFHI guidelines issued by the state has made substantial progress and the health facility has scored---------------- %(percentage of marks obtained in self-Assessment)

(Name and Address of the Health Facility)

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Hence, we request you to do the needful for assessment of the health facility for the MBFHIcertification. We assure that the hospital is fully committed to the MBFHI initiative of the State Government of Kerala and we will fully Cooperate with the assessment process and will make necessary arrangements for the assessments as per the MBFHI Process note. Detailed information on the health facility is given in the attached documents.

Thanking you.

Yours sincerely

List of attachments

1. Hospital Data sheet
2. Latest self assessment checklist with score sheet
3. Proceedings of the formation of Instituional MBFHI committee
4. Copy of the minutes of the MBFHI committee
5. Copy of the registration certificate of the hospital

**Hospital Data Sheet**

**(to be enclosed with the application for MBFHI Certification)**

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| --- | --- |
| 1. Name of Health Facility |  |
| 2. Full Address |  |
| 3. Contact Details - |  |
| a. Facility | i. Nodal Officer for MBFHI Implimentation:  ii. Email –  iii. Tel –  iv. Score of the facility on self Assessment– |
| b. Facility | i. Incharge –  ii. Email –  iii. Tel – |
| 1. Nearest Railway Station(with distance from institution) |  |
| 2. Details of Hospital | * Registration Number of the hospital with date and validity |
| a. Number of Beds | 1. Sanctioned beds – 2. Functional Inpatient beds 3. Day care Beds- |
| a. Distribution of Beds | |  |  |  |  | | --- | --- | --- | --- | |  | |  | | |  | | **Name of Unit/Ward** | | **Bed Strength** | | |  | | Medical | |  | | |  | | Female Surgical | |  | | |  | | Children’s ward | |  | | |  | | Isolation Ward | |  | | |  | | Ophthalmology | |  | | |  | | Psychiatry and De addiction Ward | |  | | |  | | Orthopaedics | |  | | |  | | Maternity | |  | | |  | | Gynaec Ward | |  | | |  | | Pay Ward/Rooms | |  | | |  | | PICU(Step down ICU) | |  | | |  | | Cardiac Intensive care unit | |  | | |  | | Medical Intensive care Unit | |  | | |  | | Surgical Intensive Care Unit | |  | | |  | | Special Newborn Care Unit | |  | | |  | | Any Other | |  | | |  | | **TOTAL** | |  | | |
| 1. Maternal Services | a. Monthly average number of deliveries for last three months-  b. Monthly average number of Caesarean Section for last three months- |
| 3. OPD Services | a. OPD Services available in the hospital –  Supporting Facilities  b. Average OPD attendance in a month  c Average IPD in a month |
| Any other relevant information |  |
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**Hospital should enter and submit the data in the prescribed form in the below mentioned link and the scanned signed copy should be send to SMD, NHM in the email id:** [**mbfhicertificationkerala@gmail.com.**The](mailto:mbfhicertificationkerala@gmail.com.The) **application will be processed only if data is entered in the google doc in the attached link** [**https://forms.gle/6NtxR55JxX9Lq3uDA**](https://forms.gle/6NtxR55JxX9Lq3uDA) **and the copy of the signed document is emailed in the above email id .**