Facility Accreditation Form for General Practitioners – Phase 1

Note: **All items marked with an asterisk (*) are regarded as minimum requirements for accreditation**

PERSONAL CREDENTIALS (to be completed by each GP in the practice)

Full name of Practitioner*	
Basic medical degree*	
List all valid post graduate degrees and diplomas	
BHF billing practice number*	
HPCSA number*	
Name of IPA the doctor is a member of	
Number of practitioners in billing practice	
Any pending or outstanding judgment with the HPCSA (if "yes" please supply more details)	Yes ☐ No ☐
Registered and currently able to dispense medication	Yes ☐ No ☐
Valid and adequate professional liability insurance	Yes ☐ No ☐
Valid and adequate public liability insurance*	Yes ☐ No ☐
Physical address*	
Postal address*	
Telephone number(s)*	Tel: ( ) Cell:
Fax number	
Email address (for personal communication)	

BILLING PRACTICE CREDENTIALS (to be completed for the billing practice as a whole)

	YES	NO
ENVIRONMENT OF CARE – PATIENT ACCESS		
Is the practice in a highly visible position?		
Is the practice within close proximity of public transport?		
Is there adequate parking at the practice?		
ENVIRONMENT OF CARE – PRACTICE PREMISES		
Signage (name and purpose of facility)*		
Emergency contact details		
Reception area (does the area ensure confidentiality and privacy?)		
Waiting room (does the area ensure safety and comfort of patient?)*		
Is there adequate toilet facilities for patients and staff?*		
Are there adequate toilet facilities for handicapped people?		
Does the practice accommodate handicapped patient/people?		
Access for emergency – accommodate vehicle		
Access for emergency – wheelchair/ambulance		
HUMAN RESOURCES (add number of staff in brackets)		
Receptionist ( )*		
Accounts and administrative staff ( )		
Nursing staff – unregistered ( )		
Nursing staff – qualified registered nurse ( )		
Dispensary staff - Dedicated ( )		
Cleaning staff ( )		
PROCEDURAL FACILITY		
Separate/Private procedure room*		
Adequate light source*		
Drip stand		
Sterilizer type: (minimum 1)*		
Autoclave		
Chemical		
Ultra violet		

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	YES	NO
ECG machine – make and serial number*		
Opthalmoscope/oroscope*		
Thermometer*		
Spirometry – make and serial number		
Ultrasound – make and serial number		
– Has the machine been serviced?		
– Do you have the necessary qualification / Training		
EQUIPMENT		
Stethescope*		
Haemoglobinometer		
Glucometer*		
Cholesterol meter*		
Electrocautry set		
Baumanometer/BP machine*		
Snellen Chart*		
Needle Holder*		
Stitch Scissors*		
Artery Forceps*		
Surgical Blade Holder*		
Cutting Scissors*		
Suture materials*		
Dressings and gloves*		
OTHER		
Lock up facility for scheduled injectibles*		
Drug register for scheduled drugs*		
Anti tetanus serum*		
Dedicated fridge for medicines and injectibles*		
Oxygen point/cylinders*		
Stock of essential drugs* [details will follow next draft]		
Clean supplies area/demarcated dirty area*		
Sharps disposable*		
Contracted removal of biodegradable waste*		
EMERGENCY EQUIPMENT		
Endotracheal tubes*		
Ambu bag*		
Laryngoscope/Airway*		
Suction machine		
On site emergency trolley		
Intravenous fluids*		
Infusion sets*		
Defibrillator		

I hereby acknowledge that the information supplied is true and I agree for a random audit to be conducted on my practice.

…… ……..

Medical Practitioner's Signature Date

Completed forms can either be faxed to 086 691 6660 or e-mailed to sonette@ipafoundation.co.za