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|  | **APPLICATION FORM FOR ACCREDITOR STATUS**  |
| **Please complete and submit this application to the Ministry** **NOTE:** The academic document, professional license and the CV of the accreditation director must be submitted with the application  |
| **1. Name of applying organization**  |
| 2. Organization category  | a. Public b. Private  |
| 3. Type of the organization  | a. Government University involved in health science education b. Health professional Association c. Other (Specify) ---------------------------  |
| 4. Address of Organization/accreditor  | Region\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sub-city\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Woreda\_\_\_\_\_\_\_\_\_\_\_\_\_ Kebele\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ House No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ P.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax No\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **MOTIVATION FOR BODY TO BE ACCREDITED** ( Attach relevant documents accreditor status request template annex M)  |
| Specify expertise in the area(s) relevant to profession ---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------  |
| 5. Do you have/arrange an office  | a. Yes b. No  |
| 6. Internet Website  | a. Yes b. No  |
|  Will you be posting lists of accredited activities on the website?  | a. Yes b. No  |

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| If so, how frequently will this be updated  |
|  Do you have/potential to hire administration assistant/secretary?  | a. Yes b. No  |
| 7. Do you have the ability or capability to assign a panel of experts (at least 5) for each CPD course accreditation  | a. Yes b. No  |
| 8. Could you mention your scope of accreditation of courses by type?  | Mention the lists of types/categories of courses you potentially accredit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 9. Do you have the designated Accreditation director?  | Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ e-Mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| 10. Potential/target applicant for course accreditation (Check as appropriate)  | Public Health Nursing Medicine Pharmacy Laboratory technology Allied health Dentistry Midwifery Anestesia Radiation profession Other, please specify\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| 11. Specify the intended mechanism for monitoring and evaluating CPD providers you will perform  |
| 12. Have you applied for CPD provider status?  | a. Yes b. No  |
| I, on behalf of the ……………………………………………………………………………… (name of the body) hereby certify that I am fully aware of and comply with the requirements of serving as an accreditor, including:  Exercising integrity and ethical conduct in the allocation of CEUs for learning activities;  Taking responsibility for quality assurance checks  Maintaining oversight of advertising accompanying the accredited activities  Recording the name of the service provider and the CEUs awarded for each CPD activity;  Submitting an annual report on activities accredited; * Safeguarding the records for at least five years
* Being subjected to quality assurance checks as may be deemed necessary by the Ministry from time to time;
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| Name of the applicant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of the applicant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of application\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |