MINISTRY OF HEALTH
BRUNEI DARUSSALAM

APPLICATION FORM FOR ACCREDITATION OF OVERSEAS HEALTH FACILITY FOR PRE-DEPARTURE MEDICAL FITNESS EXAMINATION

SECTION A: GENERAL

1. TYPE OF APPLICATION

☐ a) New application

☐ b) Renewal application (Current accreditation number: ……)

2. PARTICULARS OF HEALTH FACILITY

a) Name of Health Facility:	
b) Name of Health Facility Owner:	
c) Address of Health Facility:	Tel. No.:
	Fax No.:
	E-mail:
d) Name of Contact Person: Position:	Tel. No.:
	Mobile No.:
	E-mail:

3. REGISTRATION, LICENSING AND ACCREDITATION OF THE HEALTH FACILITY WITH NATIONAL/ LOCAL AUTHORITY

(Attach copy of registration/ licensing/ accreditation certificate or letter, where applicable)

License and Accreditation Details				
Name of Registration/ License/ Accreditation	Registering/ Licensing/ Accrediting Body	Register/ License/ Accreditation Number	Date of Issue	Date of Expiry

(Please use a separate sheet if necessary)

SECTION B: MEDICAL SERVICES

1. PERSONNEL INFORMATION

(i) Medical staff

a) How many medical doctors/physicians employed at your health facility will be performing medical fitness examinations? ☐

b) Are they in-house or visiting, fulltime or part-time? ☐ In-house ☐ Visiting ☐ Full-time ☐ Part-time

(ii) Nursing staff

a) Number of nursing staff at your health facility: ☐

(iii) Administrative/ Support staff

a) Number of administrative/ support staff at your health facility: ☐

(iv) Staff information

(Attach copy of professional qualification, professional registration, and other supporting documents)

a) List of medical personnel

No.	Name	Designation	Professional Qualification	Professional Registration Number

(Please use a separate sheet if necessary)

b) List of nursing personnel

No.	Name	Designation	Professional Qualification	Professional Registration Number

(Please use a separate sheet if necessary)

c) List of administrative / support staff

No.	Name	Designation	Highest Qualification

(Please use a separate sheet if necessary)

2. SERVICES

a) What services are offered at your health facility? (*Tick as many as appropriate*)

i. General health screening ☐

ii. Medical fitness examination ☐

iii. Occupational health services ☐

iv. Outpatient / General Practice services ☐

v. Specialty services ☐
Please specify:
……

vi. Pharmacy (or dispensing of medications) ☐

vii. Vaccination ☐

viii. Laboratory ☐

ix. Radiology ☐

x. Phlebotomy ☐

xi. Others ☐
Please specify:
……

3. LAYOUT OF HEALTH FACILITY

a) Total number of consultation/clinic rooms: ☐

b) Is there a designated area for:

i. Registration of clients/patients ☐ Yes ☐ No

ii. Administrative/Office ☐ Yes ☐ No

iii. In-house laboratory services ☐ Yes ☐ No

iv. In-house radiology services ☐ Yes ☐ No

v. Clinical procedures (e.g. ECG, audiometry, spirometry, vision test etc) ☐ Yes ☐ No
If Yes, please specify:
…….

4. REGISTRATION

a) Is there a consent form for clients/patients to agree to medical examinations? ☐ Yes ☐ No

b) How do you register clients/patients? ☐ Manual ☐ Digital

c) Do you have a standard operating procedure (SOP) for registering ☐ Yes ☐ No

clients/patients at your health facility?

d) Is the identity of clients/patients verified during registration? ☐ Yes ☐ No
If Yes, please specify how this is done.
……..……

5. RECORD KEEPING

a) How are clinical notes of clients/patients recorded? ☐ Manual ☐ Digital

b) Do you store clinical records of clients/patients? ☐ Yes ☐ No
If Yes, for how long? _____ years

c) Are medical, radiology and laboratory reports given to clients/patients? ☐ Yes ☐ No

SECTION C: RADIOLOGY SERVICES

1. REGISTRATION, LICENSING AND ACCREDITATION OF THE RADIOLOGY FACILITY WITH NATIONAL/ LOCAL AUTHORITY

(*Attach copy of registration/ licensing/ accreditation certificate or letter, where applicable*)

License and Accreditation Details				
Name of Registration/ License/ Accreditation	Registering/Licensing /Accrediting Body	Register/License/ Accreditation Number	Date of Issue	Date of Expiry

(Please use a separate sheet if necessary)

2. PERSONNEL INFORMATION

(v) Radiologists

c) How many radiologists report chest x-ray images at your facility? ☐

d) Are they in-house or visiting, fulltime or part-time? ☐ In-house ☐ Visiting ☐ Full-time ☐ Part-time

(vi) Radiographers/Technologists/Technicians

b) Number of radiographers/technologists/technicians at your facility: ☐

c) Do your radiology staff undergo training and/or competency programmes? ☐ Yes ☐ No

d) Are there appropriate and qualified personnel to oversee the quality assurance and radiation safety at your facility? ☐ Yes ☐ No

(vii) Staff information

(Attach copy of professional qualification, professional registration, and other supporting documents)

List of radiology personnel *(Including radiologists, radiographers, radiology technologists/technicians, radiation protection officers, and other relevant radiology staff)*				
No.	**Name**	**Designation**	**Professional Qualification**	**Professional Registration Number**

(Please use a separate sheet if necessary)

3. X-RAY FACILITY

a) Total number of x-ray rooms at your facility: ☐

b) Provide details on the x-ray equipment at your facility:

Type of equipment	Brand	Model	Date of installation	Date of last PPM*

(Please use a separate sheet if necessary)

*PPM – Planned preventive maintenance

c) How many chest x-ray procedures are performed at your facility each day? ☐

d) Do you have a radiation safety policy/guideline? ☐ Yes ☐ No

e) Do you have a quality control standard operating procedure (SOP) for your x-ray equipment? ☐ Yes ☐ No

f) Do you have gonad shield protection? ☐ Yes ☐ No

g) Is there a changing room for x-ray procedures? ☐ Yes ☐ No

h) Do you conduct periodic maintenance on your x-ray equipment? ☐ Yes ☐ No

i) Do you have a standard operating procedure (SOP) in place in the event of x-ray equipment breakdown? ☐ Yes ☐ No

4. IMAGE PROCESSING FACILITY

a) Type of image processing system used at your facility:

Computed Radiography System ☐

Direct Digital System ☐

Others ☐

If Others, please specify:
…….

b) Do you use radiology information system (RIS) or picture archiving and communication system (PACS)? ☐ Yes ☐ No

c) Do you have a quality control programme for image processing? ☐ Yes ☐ No

d) Do you have periodic maintenance done on your processing equipment? ☐ Yes ☐ No

e) Are the x-ray images checked and verified before sending for reporting? ☐ Yes ☐ No

5. REGISTRATION

a) Is there a dedicated registration counter at your radiology facility? ☐ Yes ☐ No

b) Do you have a receptionist and/or dedicated staff to register clients/patients? ☐ Yes ☐ No

c) Do you have a standard operating procedure (SOP) for registration and x-ray procedure at your facility? ☐ Yes ☐ No

d) Is the identity of clients/patients attending for chest x-ray verified? ☐ Yes ☐ No
If Yes, please specify how this is done.
……..

e) Do you check the pregnancy status of female clients/patients? ☐ Yes ☐ No
If Yes, how is this done?
……...

6. IMAGE MANAGEMENT

a) Do you print x-ray images on film or send image via picture archiving and communication system (PACS) for radiologist to report? ☐ Film ☐ PACS

b) Do you have criteria for acceptable chest x-ray images? ☐ Yes ☐ No

i. Are the client/patient's details and date of procedure imprinted radiographically? ☐ Yes ☐ No

ii. Is an anatomic/side marker present? ☐ Yes ☐ No

iii. Is collimation present? ☐ Yes ☐ No

iv. Are the sternoclavicular joints equidistant? ☐ Yes ☐ No

v. Are the scapulae out of the lung fields? ☐ Yes ☐ No

vi. Are the lateral chest walls included on the radiograph? ☐ Yes ☐ No

vii. Are the lung apices included on the radiograph? ☐ Yes ☐ No

viii. Are the costophrenic angles included on the radiograph? ☐ Yes ☐ No

ix. Is there good inspiration? ☐ Yes ☐ No

x. Is density 1.0 at T4 (up to T4 visible)? ☐ Yes ☐ No

xi. Do you use a physical right and left marker? ☐ Yes ☐ No

c) Do you have a reject analysis programme? ☐ Yes ☐ No

d) What is the reject rate per month? _____

7. IMAGE REPORTING

a) Do you have a dedicated reporting room? ☐ Yes ☐ No

b) Do you have a dedicated monitor to view your chest x-ray images? ☐ Yes ☐ No
If Yes, please specify the type:
…….

c) How do you report chest x-ray images?
☐ Manually written
☐ Typed on form
☐ Computerised in RIS/PACS

8. RECORD KEEPING

a) How do you keep records of chest x-ray images and reports? ☐ Manual ☐ Digital

b) How long do you keep chest x-ray images and reports? _____ years

c) Do you keep training records of your staff? ☐ Yes ☐ No

9. OTHERS

a) Do you provide a copy of the chest x-ray image and report to the client/patient? ☐ Yes ☐ No

b) Do you provide pre-employment medical examination/screening to other countries? ☐ Yes ☐ No
If Yes, please specify:
…….

SECTION D: LABORATORY SERVICES

1. REGISTRATION, LICENSING AND ACCREDITATION OF THE LABORATORY FACILITY WITH NATIONAL/ LOCAL AUTHORITY
(*Attach copy of registration/ licensing/ accreditation certificate or letter, where applicable*)

License and Accreditation Details				
Name of Registration/ License/Accreditation	Registering/Licensing/ Accrediting Body	Register/License/ Accreditation Number	Date of Issue	Date of Expiry

(Please use a separate sheet if necessary)

2. PERSONNEL INFORMATION

(i) Laboratory Pathologists

a) How many laboratory pathologists report laboratory results at your facility? ☐

b) Are they in-house or visiting, full-time or part-time? ☐ In-house ☐ Visiting ☐ Full-time ☐ Part-time

(ii) Laboratory Technologists/Technicians

a) Number of laboratory technologists/technicians at your facility: ☐

b) Do your laboratory staff undergo training and/or competency programmes? ☐ Yes ☐ No ☐ NA

c) For laboratory tests performed in-house, is there adequate staff performing laboratory testing? ☐ Yes ☐ No ☐ NA

d) For laboratory tests performed in-house, is there an appropriate and qualified staff to overs the quality assurance and laboratory safety programme? ☐ Yes ☐ No ☐ NA

e) Is there adequate laboratory staff performing sample collections at your facility? ☐ Yes ☐ No ☐ NA

f) Is there adequate staff for sample transportation and handling? ☐ Yes ☐ No ☐ NA

(iii) Staff information

(Attach copy of professional qualification, professional registration, and other supporting documents)

List of laboratory personnel

(Including laboratory pathologists/medical officers, scientific officers, laboratory technologists/technicians, phlebotomist supervisors, and other relevant laboratory staff)

No.	Name	Designation	Professional Qualification	Professional Registration Number

(Please use a separate sheet if necessary)

3. LABORATORY TESTS

Discipline	Name of lab test	Performed in-house OR referred to other lab facility*?	Equipment brand	Test method	IQC programme available? (Yes / No)	EQA programme available? (Yes / No)
Infectious Diseases	HIV antibody					
	HIV (confirmatory)					
	Hepatitis					
	Hepatitis (confirmatory)					
	VDRL / TPHA					
	VDRL / TPHA (confirmatory)					
	Malarial Parasite					
	Malaria Parasite (confirmatory)					
Drugs	Opiates / Cannabis / Amphetamines					
Urine	Urine pregnancy					
	Urine microscopic examination					
Biochemistry	*Please list relevant tests:*					
Haematology	*Please list relevant tests:*					

(Please use a separate sheet if necessary)

*To attach copy of service agreement/documentation with the referral laboratory

4. RECORD KEEPING

a) How do you keep records of laboratory results? ☐ Manual ☐ Digital

b) Do you have a unique specimen identifier for all specimen (including laboratory tests performed in-house or outsourced to a referral laboratory)?
(Note: Specimen identifier is different to patient identifier)
☐ Yes
☐ No
☐ NA

SECTION E: SUPPORTING DOCUMENTS

Please submit the following documents with your application form.

GENERAL	
1. Copy of registration/licensing/accreditation certificate with the relevant national regulatory body.	☐
MEDICAL	
2. Layout plan and pictures of the clinical set-up in the health facility including reception/registration counter, waiting area, consultation/clinic rooms, clinical procedure rooms, in-house phlebotomy area etc.	☐
3. Copy of professional qualification/training for medical doctors/physicians, including copy of professional registration license/certificate.	☐
4. Copy of professional qualification/training for nursing staff, including copy of professional registration license/certificate.	☐
RADIOLOGY	
6. Copy of radiology organisation chart.	☐
7. Copy of registration/licensing/accreditation certificate with the relevant national regulatory body.	☐
8. Copy of professional qualification/training for radiologists, including copy of professional registration license/certificate.	☐
9. Copy of professional qualification/training for radiographers / x-ray technologists/technicians, including copy of professional registration license/certificate.	☐
10. Layout plan and pictures of the radiology/x-ray facility, including reception counter, x-ray room, changing room, x-ray equipment, and image processing equipment.	☐
11. Copy of radiation safety manual and quality control procedures.	☐
12. Copy of standard operating procedure (SOP) for the x-ray service at the facility, including receiving client/patient, verifying client/patient identification, checking pregnancy status, performing chest x-ray procedure, reporting chest x-ray image, and releasing chest x-ray result and/or film.	☐
13. Copy of latest preventive maintenance and quality control results of the x-ray equipment and image processing system.	☐
14. Copy of chest x-ray request form.	☐
15. Copy of sample of chest x-ray report.	☐
LABORATORY	
16. Copy of laboratory organisation chart.	☐
17. Copy of registration/licensing/accreditation certificate with the relevant national regulatory body.	☐
18. Copy of professional qualification/training for laboratory pathologists, including copy of professional registration license/certificate.	☐
19. Copy of professional qualification/training for scientific officers / laboratory technologists/technicians, including copy of professional registration license/certificate.	☐

20. Copy of laboratory test inserts/documents stating the performance of the test methods.	☐
21. Copy of internal quality control (IQC) programme or procedure indicating: • the level of IQC performed • frequency of IQC performed	☐
22. Copy of latest quality control (IQC) results performed by the laboratory.	☐
23. Copy of latest external quality assurance (EQA) programme certificate of enrolment.	☐
24. Copy of latest external quality assurance (EQA) summary report or EQA results performed by the laboratory.	☐
25. Copy of a sample of laboratory test report.	☐
26. Copy of service agreement/ documentation of laboratory tests to a referral laboratory (if applicable). *Please attach the referral laboratory's ISO15189 accreditation certificate*	☐

SECTION F: DECLARATION

I hereby declare that the above information is true and accurate. I understand that it is my responsibility to provide any necessary documentation to support my application and I authorise the Ministry of Health to obtain further relevant documentation.

I acknowledge that the Ministry of Health reserves the right to change or reverse any decision regarding approval for this application on the basis of incorrect or incomplete information.

Name of Applicant:

Designation:

Signature of Applicant:

Date:

D	D	-	M	M	-	Y	Y	Y	Y

Healthcare Facility Stamp

All completed forms and supporting documents are to be emailed to occuphealth@moh.gov.bn