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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; | | |
| Name of the applicant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of the applicant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of application\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |