REPUBLIC OF KENYA

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KENYA MEDICAL PRACTITIONERS
AND DENTISTS COUNCIL
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NAIROBI

DENTAL INTERNSHIP TRAINING CENTRE INSPECTION/APPRAISAL /DATA FORM

SECTION 1: ADMINISTRATIVE INFORMATION
A. Facility Information
Name of institution:
Institutional head:
Medical Director/ Superintendent/Centre Head:
Internship Coordinator:
Health Administrator (where applicable)…….
Nursing Officer In-charge……
Approved Establishment for interns ----------   Current In-post for interns: _____

Facility Ownership: GOK/Faith based/Private		License number;	License Expiration date:
Registration Number		Indemnity cover number:	Indemnity Expiration date:
Physical location details			
County:		Sub-County:	
Town:		Address:	
Building plot no:		Email:	
B. Facility Level and Details			
Level of facility		☐Level 4 ☐Level 5 ☐ Level 6	
Total Bed Capacity (or arrangements)			
Bed occupancy rate (or arrangements)			
Daily Accident & Emergency patient attendance where available (or arrangements)			
Outpatient attendance (daily average)			
Workload			
C. BRIEF SUMMARY OF THE INSTITUTION			

Human Resource			
	SPECIALISTS	**NAME**	**REG. NO.**
1.	**Oral and maxillofacial surgery**		
2.	**Paediatric & Orthodontics**		
3.	**Periodontology**		
4.	**Conservative and Prosthodontics**		
5.	**Dental Public Health Specialist**		
5.	**Other Specialists (specify)**		
	Total Number of Specialists		
	Total Number of Dental Officers		
	Other Health Cadres		
6.	**Community Oral Health Officers (COHO)**		
7.	**Dental surgery assistant**		

	(Dental nurse)		
8.	**Radiographers**		
9.	**Laboratory technologists/ technicians**		
10.	**Others (specify)**		

Physical Facilities/ Services			
	Wards	**Beds**	**Occupancy (%)**
Accident & Emergency (For OMFS)			
Surgical ward (For OMFS)			
Theatre			

Dental laboratories or arrangements (or arrangements)		
Imaging Facilities		
X-Ray		
Electricity and Energy Backup		
Adequate running water		
Resource Center/ Medical Library		
Seating Capacity		
Current Journals/ Reference Books		
Internet Connection (35mbps with a booster)		

ACCOMMODATION FOR INTERNS		
NO. OF FLATS/ HOUSES (or arrangements)		
NO. OF CALL ROOMS (for OMFS)		
REGISTRY		
STORES		
HOSPITAL/FACILITY MAINTENANCE UNIT		

SLUICE ROOMS		
SHARPS CONTAINER		
WASTE MANAGEMENT SYSTEM		
OTHERS (SPECIFY)		

REGISTERED AND RUNNING CPD PROGRAMMES		
CPD COORDINATOR REG. NO:		
AVAILABILITY OF STANDARD OPERATING PROCEDURES (SOPs)		
AVAILABILITY OF A STRATEGIC PLAN		

REMARKS

Name: _____

Signature: _____

Date:

Medical Director/Medical Superintendent

OFFICIAL USE ONLY BY COUNCIL

Comments by Interns

Comments by intern supervisors, Specialists, MOs

FINDINGS

RECOMMENDATIONS
