Form .....IX.....




ORIGINAL

REPUBLIC OF KENYA

THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(Cap.253)

## APPLICATION FOR REGISTRATION OF A PRIVATE FUNERAL HOME INSTITUTION

### PART I
*(To be completed by the applicant in duplicate)*

1. NAME AND ADDRESS OF THE FUNERAL HOME INSTITUTION
*(Block Letters)*

.....

.....

.....

2. COMPANY/BUSINESS REGISTRATION CERTIFICATE NO:.....*(Attach copy)*

3. LOCATION

(a) Town/Centre/Market*.....

(b) County.....District.....

(c) Division.....Location.....

4. LOCATION OF BRANCHES (IF ANY)

.....

.....

.....

## PART II

*(To be completed by the applicant in duplicate)*

1. FULL NAMES AND ADDRESS OF THE APPLICANT
   *(Block Letters)*

……

……

……

……

……

……

2. STATE BUSINESS OWNER(S) (IF BUSINESS NAME) OR DIRECTORS (IF COMPANY) OF THE APPLICANT/FUNERAL HOME AND THEIR CURRENT ADDRESSES AND TELEPHONE CONTACTS

……

……

……

……

……

……

……

3. STATE THE SHAREHOLDERS OF THE APPLICANT/FUNERAL HOME AND THEIR CURRENT ADDRESSES AND TELEPHONE CONTACTS

……

……

……

……

4. STATE THE ADMINISTRATOR OR THE CHIEF EXECUTIVE OFFICER OF THE INSTITUTION/FUNERAL HOME AND THE CONTACTS

……

……

……

5. NATIONALITY OF THE DIRECTORS OF THE APPLICANT/FUNERAL HOME

……

……

……

……

6. KENYA NATIONAL IDENTITY CARD NO./PASSPORT NO. FOR THE DIRECTORS/OWNER(S) OF THE APPLICANT/FUNERAL HOME

……

……

……

……

*(Attach photocopy)*

7. WORK PERMIT FOR THE DIRECTORS/OWNER(S) OF THE APPLICANT/FUNERAL HOME (if applicable)

……

……

……

……

*(Attach documentary evidence – copies only)*

## PART III

*(To be completed by the applicant in duplicate)*

1. Give full names of the Pathologist who shall be in-charge of post-mortem at the Funeral Home.

   ……

   ……

   ……

2. *(a) Give full details of professional qualifications of the person named at paragraph (1) of PART III above. Include year and place where obtained.*

   *(b) State work experience of the person named at paragraph (1) of PART III above and name institutions where obtained and date.*

   *(c ) Attach documentary evidence (photocopies) in each case. (Please use extra space if necessary).*

   ……

   ……

   ……

   ……

   ……

   ……

   ……

   ……

   ……

   ……

   ……

   ……

3. *(a) Give full names and professional qualifications of any other person (s), identified by your institution, to undertake care at the institution, Laboratory Technicians, Technicians etc)*
*(b) Attach documentary evidence (photocopies) in each case. (Please use extra space if necessary)*

(i) .....

.....

.....

(ii) .....

.....

.....

(iii) .....

.....

(iv) .....

.....

.....

(v) .....

.....

.....

PART IV

*(To be complete by Medical Officer of Health in duplicate)*

INSPECTION REPORT FOR PRIVATE FUNERAL HOME INSTITUTION – FOR REGISTRATION PURPOSES

1. NAME OF INSTITUTION……

   ……

   ……

2. PHYSICAL LOCATION

   (a) Plot No./L.R. No……

   ……

   (b) Market/Centre/Town*……

   ……

   (c) Street/Road*……

   ……

   (d) County……District……

   Division……Location……

3. PREMISES GENERAL INFORMATION

   (a) Plot Area (in hectares)……

   ……

   (b) Water supply……

4. Environmental suitability……recommended/not recommended.* State reasons for not recommending:

   ……

   ……

   *(Attach approved letter from NEMA)*

5. PLAN OF THE INSTITUTION recommended.* State reasons for not recommending:
   (a) Approved/Not approved* by the local District Development Committee (attach copy of the plan) and documentary evidence (copies) of approval of the institution by the D.D.C.

6. OTHER REQUIREMENTS

   (i) Refrigerated/Not refrigerated.*

   (ii) Appropriately located/Not appropriately located.*

   If not appropriately located state why……

   ……

   (iii) Body capacity……

   (iv) Adequate Privacy/Not Adequate Privacy.*

   (v) Number of ambulances……

   (vi) Protective gear for personnel……

   (vii) Policies and procedures ……..

   ……..

   ……
   *(for identification, disinfection preservation, storage, include disposal of unclaimed bodies)*

   (viii) Other facility (specify and use extra space if necessary)

   ……..

   ……

7. Give full names and designations of members of the D.H.M. T. who participated in the inspection of the institution.

| NAME | DESIGNATION |
|---|---|
| (i) ..... | |
| (ii) ..... | |
| (iii) ..... | |
| (iv) ..... | |
| (v) ..... | |
| (vi) ..... | |
| (vii) ..... | |
| (viii) ..... | |
| (ix) ..... | |

8. CERTIFICATE BY M.O.H

I, Dr.……

*(State full names in Block Letters)*

Being the Medical Officer of Health in-charge……District, do hereby certify that the inspection of ……..was conducted by the District Health Management Team of……..on ……day of……20…….. under my personal supervision.

I further certify that the inspection was witnessed by Dr./Mr./Mrs./Miss…… ……..being the Owner/Director/Applicant* and that…….. the said institution does/does not* meet the minimum requirements for Registration/Licensing purposes.

Dated this……day of ……..,20……

Signature……

*(Medical Officer of Health)*

Name of Station……

Address……

Telephone No……..Mobile……

---

PART V

I, Dr./Mr./Mrs./Miss*……

*(Full Names in Block Letters)*

hereby certify that all information given by me in this application form is true and correct and that I personally witnessed the inspection which was conducted by the Medical Officer of Health on ……..day of ……..,20……

Signature……

APPLICANT TO NOTE:

This application form must be returned to the Medical Practitioners and Dentists Board together with the required fees within a period not exceeding one month from the date of issue.

(i) Application Fee =Kshs.1,000.00
(ii) Registration Fee =Kshs.5,000.00
(iii) Annual Licence Fee =Kshs.20,000.00

Applications which are not returned within the stipulated period shall be time barred.

## PART VI

*(For the purposes of vetting applications and enforcement of Laws, Regulations and Decisions of the PPC)*

Recommendations:

Recommended/Not Recommended ……

*(If not give R*easons)……

Name:…… Designation:……

Date:……

APPROVED/NOT APPROVED

(*If not approved, give reasons*): ……

……

……

……

Dated this……day of……,20……

……

*Chairman PPC*
*Medical Practitioners and Dentists Board*