

# APPLICATION FORM international Accreditation Programme

**1.0 GUIDANCE**

The Application Form is required to be completed by all organisations who wish to apply for the International Society for Quality in Health Care External Evaluation Association (ISQua EEA) International Accreditation Programme (IAP). All applicants are required to adhere to the IAP Terms and Conditions (For more details please see *Terms and Conditions* (Ref IAP-I-12).

Prior to completion of the application please ensure that:

1.1 Introduction to IAP (Ref IAP-I-14) has been reviewed to ensure clarity with regards to the various products.

1.2 Access fee has been paid (for first time applications only).

1.3 Current fee schedule has been reviewed (Ref IAP-I-13).

The information on this form will be used by ISQua EEA to ensure that the scope of the survey is accurate. You will be asked to update a summary of this document for the surveyors to gain insight into your organisation, therefore please complete all sections. For any additional enquires please contact ISQua EEA: [support@ieea.ch](mailto:support@ieea.ch).

**2.0 ORGANISATIONAL PROFILE**

Please complete all fields. If any field is not applicable to your organisation please mark as N/A.

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| **Organisation Details -** | | | | | | |
| 2.1 | Parent Company: (in English): & Local Language | | | Applicant Organisation Name: | | |
|  |  | | |  | | |
|  |  | | |  | | |
|  | Year of initial operation: |  | | | | |
|  | Scope of Business, e.g. accreditation, certification, inspection, evaluation, standards setting, delivering quality and patient safety training programmes | | | | | |
|  |  | | | | | |
| 2.2 | Applicant Organisation Address: | | | | | |
|  |  | | | | | |
| Telephone | | | Website | | | |
|  |  | | | | | |
| 2.3 | CEO *(or equivalent):* |  | | | | |
| Telephone: | | | Email: | | | |
| 2.4 | Contact Person 1 *(name and title):* |  | | | | |
| Telephone: | | | Email: | | | |
| 2.5 | Contact Person 2 *(responsible for invoicing/finance, if different from above)*: | | | |  | |
| Telephone: | | | Email: | | | |
| 2.6 | Number of employees: |  | | | | |
| 2.7 | Number and location of offices: |  | | | | |
|  |  | | | | | |
| **Standards Details – Please only complete questions 2.8 – 2.11 if you are seeking standards, organisational or surveyor training programme accreditation** | | | | | | |
| 2.8 | All sets of standards in use, including revision/version number and year of approval | | | | | Please tick if you wish these standards to be accredited: |
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| 2.9 | Please state who has ownership of the standards: | | | | | |
|  |  | | | | | |
| **Survey/Assessment Details** | | | | | | |
| 2.10 | Number of surveys in the last calendar year: | | | | | |
|  |  | | | | | |
| **Surveyor Training Details** | | | | | | |
| 2.11 | Do you deliver your own surveyor training programme? | | | | | |
|  |  | | | | | |
| **Quality and Patient Safety Training Programme – Please complete questions 2.12 – 2.14 if you wish to get a quality and patient safety training programme assessed** | | | | | | |
| 2.12 | Please provide details regarding the training programme that you wish to get assessed (please include the full name of the training programme) | | | | | |
|  |  | | | | | |
| 2.13 | When was this training programme first delivered (year)? | | | | | |
|  |  | | | | | |
| 2.14 | How many trainees/learners have completed the training programme to date? If this is the first year that the training programme is being delivered please indicate the current number of trainees/learners enrolled on the programme? | | | | | |
|  |  | | | | | |
| **General** | | | | | | |
| 2.15 | Other comments/additional information | | | | | |
|  |  | | | | | |

**3.0 PRODUCTS REQUIRED**

Please specify the accreditation services you require. Please note that Organisational Accreditation **can only be undertaken following Standards Accreditation**.

|  | **IAP Products** | **Required?**  **Yes/No** | **Preferred Date for Survey/Assessment\*** |
| --- | --- | --- | --- |
| **A** | **Standards Accreditation**  (If more than one set of standards please state the number) |  |  |
| **B** | **Organisational Accreditation** |  |  |
| **C** | **Surveyor Training Programme Accreditation** |  |  |
| **D** | **Quality and Patient Safety Training Programme** |  |  |

\*Please note that while every effort will be made to accommodate your preferred dates, we cannot confirm that your preferred dates will be available. A minimum of ten months is required from time of application to survey.

**4.0 PAYMENT PROCESS**

On receipt of your Application Form, ISQua EEA will issue an invoice for the required amount, as specified in the current fee schedule (Ref IAP-I-13).

All applications will be processed upon receipt of full payment of the issued invoice. At this time you will be contacted to determine the dates for your survey(s). Once dates are confirmed you will be provided with access to our online survey management tool *ISQua EEA Collaborate* which includes the relevant documents from the following list:

* Guidelines and Principles for the Development of Health and Social Care Standards, 5th Edition
* Guidelines and Standards for External Evaluation Organisations, 5th Edition
* Guidelines and Standards for Surveyor Training Programmes, 3rd edition
* Guidelines and Standards for Quality and Patient Safety Training Programmes, 1st Edition
* Self-Assessment Tool to be completed
* Sample of Completed Self-Assessment

**5.0 POSTPONEMENT / CANCELLATION OF SCHEDULED SURVEY**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [**Name of organisation**] hereby states that it is aware of, and agrees to abide by the *Terms and Conditions of the ISQua External Evaluation Association International Accreditation Programme* (Ref IAP-I-12), including those relating to postponement or cancellation of a scheduled survey.

**6.0 SUBMISSION**

I wish to submit the above application for consideration and in doing so agree to adhere to the *Terms and Conditions of the ISQua External Evaluation Association International Accreditation Programme* (Ref IAP-I-12).

Signed:

Name (print):

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:

**Please return the completed form to ISQua EEA:** [**support@ieea.ch**](mailto:support@ieea.ch)

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| --- |
| Office Use Only - Date of Receipt: DOI: REF: |

**International Society for Quality in Health Care External Evaluation Association (ISQua EEA), Multifiduciaire Genève, Carrefour de Rive 1,**

**Case Postale 3369, 1211 Genève 3, Switzerland.** [**support@ieea.ch**](mailto:support@ieea.ch)