

Republic of the Philippines
Department of Health
Philippine Health Insurance Corporation
and
Research Institute for Tropical Medicine
Antimicrobial Resistance Surveillance Program

APPLICATION FOR ACCREDITATION OF AEROBIC BACTERIOLOGY LABORATORY
(To be accomplished by Pathologist)

Part I. Laboratory Information:

Date of application: _____ New [] Renewal []
MM/DD/YY

Name of Institution/Laboratory: _____

Category of Lab -

Classification of laboratory by level:

Health Facility: _____
District : _____
Provincial : _____
Regional : _____
National : _____

Classification of laboratory by ownership:

Government: _____
Private : _____
Number of cultures performed per year: _____

Address : _____
No. Street Barangay

_____ Municipality/City Province Region Zip code

Telephone No: _____ Facsimile No: _____
Area code + Phone #

BHFS License Permit No: _____ Validity Date: _____
MM/DD/YY

Part II. Organization Data:

A. Name of Hospital Director: _____
Surname First Name M.I.

B. Head of Laboratory: _____
Surname First Name M.I.

Address : _____
No. Street Barangay

_____ Municipality/City Province Zip code

Telephone No : _____ Facsimile No: _____
Area code + Phone #

PRC License No : _____ Validity Date: _____
MM/DD/YY

Date of certification by the Philippine Society of Pathology: _____
MM/DD/YY

Name of specialty board: [] AP, [] CP, [] AP-CP, [] others (specify) _____

C. Staffing

Laboratory Staff	Name	Position Title	Educational Attainment	PRC No/ Validity
1. Clinical Microbiologist				
2. Hospital Epidemiologist				
3. Technical Consultant				
4. Bacteriology Supervisor				
5. Medical Technologist				
6. Laboratory Assistant/ Technician				
7. Laboratory Aide				
8. Clerk				

Note: Please use separate sheet if necessary.

Part III: Service Capabilities

TEST	(✓) if done	Send-out		
		Name of Laboratory	Address	Telephone
1. Gram's Staining				
2. Culture (Isolation and Identification)				
3. Susceptibility Testing				
4. Others, (specify)				

Part IV. Fees

Initial accreditation and renewal fee: (Non-refundable) P 1500.00

EQAS fee (Non-refundable) 5,500.00

Mode of Payment: Cash: (ARSP-RITM Cashier) _____

Amount

Check: (Payable to Research Institute for Tropical Medicine)

Check Number

Amount

Bank/ Branch

Date

If you do not receive an acknowledgement receipt within 3 weeks after submission of application form, please call ARSRL office at 02 8099763.

Part V: Declaration

I hereby certify that the foregoing statements are true. I hereby submit this application for accreditation under ARSP and agree to comply with the rules and regulations of PHILHEALTH CIRCULAR No. 15, s- 2006.

Name in Print and Signature

Designation

PTR

Date

Republic of the Philippines)
Manila) S.S.

Before me at Manila this ___ day of _____, came and appeared the following and exhibited his Community Tax Certificate as shown above known to me and to me known to be the same persons who executed the foregoing **Application for Accreditation of Aerobic Bacteriology Laboratory** and acknowledged the same as their voluntary act and lawful deed.

CTX No. _____ issued at _____ on _____

This document consisting of four (4) pages, including this on which the acknowledgement is written has been signed by the parties and their witnesses on each and every page thereof and pertains to an application for accreditation.

WITNESS MY HAND AND SEAL

Doc. No. ____
Page ____
Book No. ____
Series of _____

ATTY. _____
Notary Public
Until _____
IBP No. _____