KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

APPLICATION FOR LICENCING OF A VIRTUAL MEDICAL SERVICES PROVIDER

This form is to be filled in by the medical director, who is responsible for clinical care delivery through the telecommunication infrastructure, who is registerable by a regulatory body within the Republic of Kenya.

A. DETAILS OF THE VIRTUAL FACILITY				
Name of the link health facility:				
Name of the Virtual facility:				
Type of Services to be offered: (Tick (✔) as appropriate)	☐	Telemedicine;	☐	Robotic medicine;
	☐	E-health;	☐	E-learning; and
	☐	M-health;	☐	Artificial intelligence

Requirement:

1. Attach a cover letter describing the services you intend to offer.
2. Attach a copy of the link health facility's current KMPDC operating license.

B. DETAILS OF THE MEDICAL DIRECTOR	
Name:	
KMPDC Reg. No.	
ID/Passport Number:	
Nationality:	
Physical Address:	
County:	
Mobile Number:	
E-Mail Address	

Required documents:

3. Attach a copy of the Medical Director's Current Practice License.

C. DETAILS OF ALL THE MEDICAL/DENTAL PRACTITIONERS PROVIDING SERVICES VIA THE VIRTUAL FACILITY

NO.	NAME OF PRACTITIONER	KMPDC REG. NO.	HIGHEST QUALIFICATION
1.			
2.			
3.			
4.			

4. Attach copies of the Current Practice Licenses of **ALL** the practitioners providing medical/dental services via the virtual facility. If number exceeds FOUR (4), attach a separate list of the practitioners to this form
5. A fee of Kshs. 50,000.00 to accompany this application.

D. DECLARATION BY THE MEDICAL DIRECTOR

I, Dr._____of KMPDC Reg. No._____do hereby commit to ensure the virtual facility shall adhere to the following provisions:

a) **THAT** all practitioners shall meet the registration and licensing requirements under CAP 253 - Laws of Kenya and attending rules;
b) **THAT** all practitioners shall provide services within their scope of practice;
c) **THAT,** as the medical director, I shall maintain a list of all licensed medical and dental practitioners providing virtual services;
d) **THAT** practitioners **SHALL NOT** use collected personal health information for research without ethical approval;
e) **THAT** the virtual facility shall maintain a record of all services provided;
f) **THAT** all the practitioners shall ensure compliance with the Ministry of Health policies on telemedicine, eHealth and any other related areas, to address data storage and systems standards, data privacy and security and interoperability of the system among others; and
g) **THAT** provisions of the Data Protection Act shall be adhered to.

FURTHER you hereby declare that the information given above is true to the best of YOUR knowledge and belief.

Signature:		Date:	

FOR OFFICIAL USE:

PREPARED BY: Name: …… Designation: …… Signature: ……... Date: …….....	**APPROVED/NOT APPROVED:** Name: ……. Designation: …...……
CHECKED BY Name: …… Designation: …...…… Signature: ……... Date: …….....	Signature: ……... … Date: …….....