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

APPLICATION FOR ARSP ACCREDITATION OF BACTERIOLOGY LABORATORY

PT - ☐☐☐☐
(ARSP Secretariat Use)

Date of Application *(dd/mmm/yyyy)*		Status of Application: *(select appropriate)* ☐ New ☐ Renewal

PART I: HOSPITAL INFORMATION

Address:

Number *Street* *Barangay*

Municipality/City *Province* *Region* *Zip Code*

Telephone No:	BHFS License Permit No:
Facsimile No:	Validity Date: *(dd/mmm/yyyy)*

Classification according to: *(select appropriate)* *Based on DOH A.O. 2012-0012 "Rules and Regulations Governing the New Classification of Hospitals and Other Health Facilities in the Philippines"*	Ownership ☐ Government ☐ Private
	Functional Capacity*: ☐ Level 1 ☐ Level 2 ☐ Level 3 **For General Hospitals only*

Name of Hospital Director/Chief:

Last Name *First Name* *M.I.*

PART II: LABORATORY INFORMATION - BACTERIOLOGY SECTION

Classification according to Service Capability: *(check appropriate)* *Based on DOH A.O. 2007-0027 "Revised Rules and Regulations Governing the Licensure and Regulation of Clinical Laboratories in the Philippines*	☐ Primary ☐ Secondary ☐ Tertiary
Telephone No:	Telephone No *(Direct Line):*
	Mobile No:
Facsimile No:	Email Address:

Name of Head of Laboratory:

Last Name *First Name* *M.I.*

Laboratory Staff	Name	Position Title	Educational Attainment	PRC No. / Validity	No. of years assigned in Bacteriology Section
1. Section Head					
2. Medical Technologist					

No. of Permanent Staff assigned in Bacteriology Section:	

ARSRL Contact Details:
☎: (02)88099763 | (02)88072631/32/32 local 243
✉ : eqap@arsp.com.ph | 💻 : www.arsp.com.ph

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PART III: TEST DONE IN BACTERIOLOGY LABORATORY ***(check appropriate)***

☐ Gram's Staining

Culture (Isolation and Identification)

☐ Conventional ☐ Automated *(Specify machine used):* _____

Susceptibility Testing

☐ Disk Diffusion ☐ MIC ☐ E-Test ☐ Automated *(Specify machine used):* _____

Special Tests

☐ PCR ☐ Serotyping ☐ Other *(Specify):* _____

PART IV: FEES *(To be filled up by ARSRL Secretariat)*

Please deposit payment of _____ to the indicated bank below. Enclose original deposit slip together with the application requirements. Official receipt shall be sent through courier together with the sample for Proficiency Testing.

Land Bank of the Philippines, Alabang Business Center Branch Account Name: Research Institute for Tropical Medicine Account Number: 3832-1001-36	*O.R. Number* *Date Deposit (dd/mmm/yyyy)*

Note: *If you do not receive an acknowledgement receipt within 3 weeks after submission of application form, please call ARSRL office at* ***(02) 8809-9763*** *or* ***(02) 8807-2630 local 243.***

PART V: DECLARATION

I hereby certify that the foregoing statements are true. I hereby submit this application for accreditation under Antimicrobial Resistance Surveillance Program and agree to comply with the rules and regulation of ADMINISTRATIVE ORDER NO. 2015-0049.

Name in Print and Signature	Date
Head of Laboratory	
Designation	PTR

Checklist of Requirements	
	1. Floor plan of Bacteriology Section (Photocopy)
	2. Pictures of Bacteriology Section
	3. Hospital License to Operate (Photocopy)
	4. Notarized affidavit of Undertaking signed by Hospital / Medical Director
	5. Original Copy of deposit slip

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