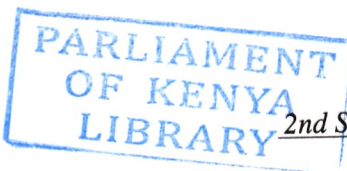


SPECIAL ISSUE

Kenya Gazette Supplement No. 144



2571

2nd September, 2016

(Legislative Supplement No. 65)

LEGAL NOTICE NO. 157

THE CLINICAL OFFICERS (TRAINING, REGISTRATION AND LICENSING) ACT

(Cap. 260)

IN EXERCISE of the powers conferred by section 16 of the Clinical Officers (Training, Registration and Licensing) Act, the Cabinet Secretary for Health makes the following Regulations—

THE CLINICAL OFFICERS (TRAINING, REGISTRATION AND LICENSING) (FORMS AND FEES) (AMENDMENT) REGULATIONS, 2016

1. These Regulations may be cited as the Clinical Officers (Training, Registration and Licensing) (Forms and Fees) (Amendment) Regulations, 2016.

Citation.

2. The Clinical Officers (Training, Registration and Licensing) (Forms and Fees) Regulations herein after referred to as "principal Regulations"

Subleg

3. The principal Regulations are amended by deleting regulation 7.

4. The principal Regulations are amended by deleting regulation 10 and substituting therefore the following regulation—

Application for a medical training institution.

10. (1) An application for a license to start a medical training institution for training clinical officers shall be in Form COC 13 set out in the First Schedule.

(2) A license to start a medical training institution for training clinical officers shall be in Form COC 14 set out in the First Schedule.

5. The principal Regulations are amended by deleting regulation 11.

Application for indexing.

11. An application for indexing shall be in Form COC 15 set out in the First Schedule.

6. The principal Regulations are amended by deleting regulation 12 and substituting therefore the following regulation—

Index card

12. An index card issued by the Council shall be in Form COC 16 set out in the First Schedule.

7. The principal Regulations are amended by inserting the following new regulation immediately after regulation 12—

Application for practicing licence. 12A. An application for practicing license shall be in form COC 17 as set out in the First Schedule

8. The Schedule to the principal Regulations is amended by—

- (a) deleting Form COC 2 and substituting therefor the new Form COC 2 set out in the First Schedule;
- (b) deleting Form COC 4 and substituting therefor the new Form COC 4 set out in the First Schedule;
- (c) deleting Form COC 10;
- (d) deleting Form COC 11 and substituting therefor the new Form COC 11 set out in the First Schedule;
- (e) deleting Form COC12 and substituting therefor the new Form COC 12 set out in the First Schedule;
- (f) deleting Form COC 13 and substituting therefor the new Form COC 1 set out in the First Schedule;
- (g) deleting Form COC 14 and substituting therefor the new Form COC 14 set out in the First Schedule;
- (h) deleting Form COC 15;
- (i) inserting the new Form COC 17 set out in the First Schedule;

9. The principal Regulations are amended by deleting the Second Schedule and substituting therefor the Schedule set out in the Second Schedule.

FIRST SCHEDULE

Form COC 2 (r. 3(1))

THE CLINICAL OFFICERS (TRAINING, REGISTRATION AND LICENSING) ACT
(Cap. 260)

APPLICATION FOR REGISTRATION AS A CLINICAL OFFICER

1. Name.....ID No.....
(in full-BLOCK LETTERS)
 2. Nationality..... Date and Place and of Birth.....
 3. Gender.....
 4. Permanent Address..... Tel No.....
Place of work Address Tel No.....
 5. Qualification (Degree or Diploma held, name of the Training Institution and date of qualification)
 6. Particulars of experience (e.g. length of service in the public institution, post held, type of practice in which engaged, other country where applicant has practiced) dates must be clearly stated -
 7. Registration number and date place of original registration.
(where applicable).....
 8. Testimonials from your* Immediate Supervisor/Employer/Head of Faculty (Training Institution) covering the period of experience should be attached.....
- Signature of applicant..... Date.....

N.B.- Photocopies of Certificate/Testimonial should be attached to this application. The Original Certificate should be brought in person during the Registration.

*Delete where not applicable

Note:

Any person who gives false information in this form commits an offence and is liable to a fine not exceeding 50,000 thousand shillings.

THE CLINICAL OFFICERS (TRAINING, REGISTRATION AND LICENSING) ACT
(Cap. 260)

APPLICATION FOR LICENCE TO RENDER MEDICAL AND SURGICAL SERVICES IN AN APPROVED MEDICAL INSTITUTION BY AN INTERN

Intern Licence No.....

1. Mr./Mrs/Miss..... ID/No.....

(in full-BLOCK LETTERS)

2. Nationality..... Place and Date of Birth

3. Permanent Address..... Tel No.....

Place of work address.....Tel No.....

4. Qualification: Diploma or Degree held* (give name of Training Institution attended and date of qualification)

5. Place and institution of internship

.....
.....
.....
.....

Signature of Applicant.....Date.....

*Delete where not applicable

Note:

Any person who gives false information in this form commits an offence.

THE CLINICAL OFFICERS (TRAINING, REGISTRATION AND LICENSING) ACT

(Cap. 260)

INTERN ASSESSMENT FORM

Name in Full.....

Intern Licence No.....

Discipline:

1. Medicine.....From..... To
2. Paediatrics.....From..... To
3. Surgery.....From.....To.....
4. Obstetrics and Gynaecology From.....To.....
5. Community Health.....From.....To.....

(Where applicable)

6. Health Services Management (Where applicable)

Knowledge of Clinical Skills	Grading				Remarks	
	A	B	C	D		
1. Medicine:						
(i) Patient History + Recording						
(ii) Clinical Examination						
(iii) Interpretation of Laboratory Data/ X-rays						
(iv) Progress Notes on Patients						
(v) Use of Drugs (Therapeutics)						
(vi) Patient Management						
(vii) Performance and Procedures						
2. Paediatrics	A	B	C	D		
(i) History Taking + Recording						
(ii) Clinical Examination						
(iii) Interpretation of Laboratory Data and/or X-rays						
(iv) Progress Notes on Patients						
(v) Use of Drugs (Therapeutics)						
(vi) Patient Managements						
(vii) Performance and Procedures						
Knowledge of Clinical Skills	Grading				Remarks	
3. Surgery	A	B	C	B		

(i) History Taking and Recording					
(ii) Clinical Examination					
(iii) Interpretation of Laboratory Data / X-rays					
(iv) Progress Notes on Patients					
(v) Use of Drugs (Therapeutics)					
(vi) Patient Management					
(vii) Performance and Procedures					
4. Obstetrics and Gynaecology:	A	B	C	D	
(i) History Taking + Recording					
(ii) Clinical Examination					
(iii) Interpretation of Laboratory Data/X-rays					
(iv) Progress Notes on Patients					
(v) Use of Drugs (Therapeutics)					
(vi) Patient Managements					
(vii) Performance and Procedures					
5. Community Health (Components)					
6. Health services management (where applicable)					
7. Sense of Responsibility:					
(i) To Patients					
(ii) To Associates (Colleagues)					
(iii) To the Public					
(vi) Punctuality + Availability					

Overall Supervisor's Assessment

Point* 4 = A = Excellent

3 = B = Good

2 = C = Satisfactory

1 = D = Unsatisfactory

Note: - If one scores "A" in all areas*, the maximum score will be 123 points

*Delete where not applicable

DISCIPLINE:-

1. Medicine:

Name of the Hospital.....

Name of Consultant/In-Charge of Department

Qualifications.....

Date.....

Signature.....

2. Paediatrics:

Name of Consultant/In-Charge of Department.....

Qualifications.....

.....

.....

.....

Date

Signature.....

3. Surgery:

Name of Consultant/In-Charge of Department.....

.....

Qualifications.....

.....

.....

.....

.....

Date

Signature.....

4. Obstetrics and Gynaecology:

Name of Consultant/In-Charge of Department.....

.....

.....

.....

Qualifications.....

.....

.....

.....

.....

.....

Date

Signature.....

5. Community Health:

Name of Consultant/In-Charge of Department.....

.....

.....

.....

.....

Qualifications.....
Date

Signature.....

6. Health Services Management:

Name of Consultant/In-Charge of Department

.....
.....
.....
.....

Qualifications.....

.....
.....
.....
.....

Date.....

Signature.....

HOSPITAL ADMINISTRATION:- (CLINICAL OFFICER I/C)

I certify that the above-named clinical officer practitioner was engaged in full time training employment in the discipline specified above in accordance with section 7(1) (a) of the Act.

Comments.....
.....
.....

Name in full.....

Date.....

Signature.....

NB:- Additional Confidential Report by Consultant can be attached to the final report and forwarded to the Registrar.

To:

THE MEDICAL OFFICER OF HEALTH/*COUNTY

MEDICAL OFFICER (NAIROBI) DISTRICT

P.O BOX.....

.....

CLINICAL OFFICERS COUNCIL
PRIVATE CLINIC INSPECTION REPORT

LIC NO.....

(Where applicable)

Name..... Reg No.....

Clinic Name..... Plot No.....

Address..... Market.....

Sub County..... County.....

- 1. Structure:.....
- 2. Permanent.....
- 3. Semi-Permanent.....
- 4. Temporary.....
- 5. State of Structure.....

Rooms And Sizes (Minimum Size-10ft X 10ft.(3x3)Metres

Kitchen (Where Applicable)

Laboratory

Adequate: Lighting

Water Supply.....

Sanitation.....

6. Equipment:

Furniture.....

Medical Equipment.....

Table.....

Stove.....

Chairs.....

Sterilizer.....

Benches.....

Trays.....

- Cupboards.....
- Kidney dishes
- Examination Couch.....
- Forceps, e.g.....
- No. of Beds (where applicable)
- Sphygmomanometer...
- Computer.....
- Diagnostic set/spatulas
- Thermometers.....
- Uristics.....
- Suture materials
- Torch.....
- Oxygen cylinder (where applicable)
- Microscope (where applicable)
- Blood analyses (where applicable)
- Centrifuge (where applicable)
- Incubator (where applicable)
- N.B:- Equipment applicable to clinic or medical centre.

7. RECORDS:

- OPD Registrar
- Drugs Register/Drug Purchase receipts
- Patient OPD Card/IP FILES.....
- Patient Record Card/ File or Registrar

- 8. Drug Storage Facilities Available.....
-
-
-
-

- 9. Personnel (if applicable).....
-
-
-
-

Comments:

.....

.....
.....
.....

Public Health Officer/Public Health Technician

County/ Sub-County.....

Sub-County Clinical Officer

Medical Officer of Health

County.....

cc. The COUNTY DIRECTOR FOR HEALTH :.....

County.....

COUNTY DIRECTOR of Health COUNTY

cc. DMS

Form COC 13

(r. 10)

CLINICAL OFFICERS COUNCIL

APPLICATION FOR STARTING CLINICAL MEDICINE TRAINING PROGRAMME

Name of the Insitution:-

County:-.....

Sub-County.....

Town (City).....

Plot No.....

Address.....

Registration by Ministry of Education.....

ATTACHMENT HOSPITAL

Name.....

Distance From Facility.....

Bed Capacity.....

Occupancy.....

Consultants.....Medicine.....No.....

Surgery.....

Paediatrics.....

Ops/Gynae.....

Laboratory.....

TEACHING STAFF

Cadres.....

No.....

Total Number of Students intake per Year.....

Land Reference Number of the Land Occupied.....

Acrage.....

Hostels.....

Class Room.....

Demonstration Room..... Lab.....

Library.....

Laundry.....

Kitchen.....

Dining Hall.....

Abolution Block/Toilet & Bathroom.....

Playing Ground.....

Administration /Block.....

Offices.....

Stores.....

Abolution Block/Toilet &

Bathroom.....

Waste Management.....

Name of Applicant.....

Title.....

Qualifications.....

Form COC 14

(r. 10 (2))

CLINICAL OFFICERS COUNCIL
CERTIFICATE OF REGISTRATION

AS A TRAINING INSTITUTION FOR CLINICAL MEDICINE

Name of the Institution.....

Address.....

Plot No.....

Has been licensed as a Training Institution for Clinical Officers in accordance with rule.....the Clinical Rules.

Dated thisday of..... 200.....

This licence is valid for a period of three years from the date of issue.

.....

Chairman COC

Registrar COC

Note:- Any change of the address or plot No. must be communicated to the Registrar within two weeks (14 days)

Form COC 15

(r. 11(1))

CLINICAL OFFICERS COUNCIL
APPLICATION FOR INDEXING

.....
.....

INDEX NUMBER

(Official use only)

NO. _ _ _ _ _

Surname (Mr/Mrs/Miss)

(e.g. Father's/Husband Name) (Full Names in Block Letters)

First Name..... Religious Names (S).....

Citizenship:..... ID. No/Passport No.....

Date of Birth: Day..... Month..... Year..... Age.....

Secondary School Attended:.....

Certificate Held:..... Certificate No.....

Grade

Name of Training School/Hospital.....

Date of Commencement of Training.....

If previously indexed with this Council, state PHOTOGRAPH



Index No.....

If previously Registered with
this Council (state Registration Number)

Registration/Enrolment No.....

Date of Registration/Enrolment.....

Index Fee of Kshs.....Enclosed

Candidates Signature.....

To the best of my knowledge the particulars given above in respect above in respect of the applicant are correct.

Full Name.....

Head of Department

Signature..... Date.....

Designation.....

NB. If the names given at the top of this form is different from that under which the applicant is already registered with this Council, documentary evidence of legal change of name must accompany this form.

THIS FORM MUST BE COMPLETED AND RETURNED TO:-

THE REGISTRAR CLINICAL OFFICERS COUNCIL

P.O BOX 19795 K.N.H

NAIROBI, KENYA

WITHIN 30 DAYS OF COMMENCEMENT OF TRAINING

Please note that the name given above is the one under which the applicant will be indexed and which must be used in all communications with this Council.

COC FORM 17

CLINICAL OFFICERS COUNCIL

(TRAINING, REGISTRATION AND LICENSING) ACT (CAP. 260)

APPLICATION / RENEWAL OF PROFESSIONAL PRACTICE LICENSE FORM

P.O. Box 19795- 00202, K.N.H.Nairobi|Tel:+254725705144|Email:
info@clinicalofficerscouncil.org Website.www.clinicalofficerscouncil.org Location:
Kindaruma road, Kamburu Drive , Blue Violet Plaza 2nd Floor

The application must be completed in full and be submitted to the Registration and Licensing Department of the clinical Officers Council before expiry of a practicing license (every 2 years) or upon successful completion of Internship.

All payment to the council should be made through the following bank account

Co-operative Bank –Nairobi Business Centre Branch -01102039922700

REQUIRED ATTACHMENTS

1. Copy of Clinical Officers Council Registration Certificate

2. Copy of National Identity Card
3. Two colored passport size photographs
4. Expiring original Practice License and
5. Evidence of having undergone 30 points of Continuous Professional Development every year , CPD Diary

NEW	RENEWAL
-----	---------

REGISTRATION NUMBER

.....

SECTION A: APPLICANT INFORMATION

First Name.....Middle Name(s).....Surname.....

Other Names if not as in your certificates

(Attach Testimonials)

Date of Birth...../...../..... ID No.....

Current Postal Address..... Code..... Town..... Mobile No.....

Current Email Address.....

Qualifications (tick as Appropriate)

BSc. Clinical Medicine

Higher Dip (specify)

Diploma Clinical Medicine

Others (specify)

Current Working Station

DECLARATION: I do hereby declare that the information herein is the truth to the best of my Knowledge

Signature of applicant Date

OFFICIAL USE ONLY

1. Received By..... Date.....Sign.....

2. Approved By..... Date..... Sign.....

3. Verified By Date Sign.....

SECOND SCHEDULE

SECOND SCHEDULE

r. 23

Fees payable under the Act

	Shs.
1. Registration as a qualified clinical officerDiploma	7,000
Degree	7,500
2. Reinstatement of name in the register	10,000
3. Full time medical or dental practitioner	10,000
4. Assessment on request	10,000
5. Licence to render medical services in non-government institution	10,000
6. Licence to practice part time	5,500
7. Change of premise	5,000
8. Indexing fee	5,000
9. Assessment fee.....	5,000
10. Late renewal of licence50%...of the prescribed fee	5,000
11. Inspection of training institutions	500,000
12. Internship License.....	500
13. Internship booklet	500
14. Inspection forms	1,000
15. CPD booklet.....	500
16. Inspection Checklist for new training institutions.....	20,000
17. Re-Inspection for the institutions.....	500,000
18. Core Curriculum guide.....	50,000
19. Retention bi-annually.....	2,000
20. CPD provider application.....	15,000
21. CPD provider Accreditation.....	30,000

Dated the 2nd August, 2016

CLEOPA MAILU,
Cabinet Secretary for Health.