

Department of Tourism
Office of Tourism Standards and Regulation



SELF-ASSESSMENT CHECKLIST Ambulatory Clinic

NAME OF CLINIC : _____

BUSINESS ADDRESS: _____

TELEPHONE NO. : _____ FAX NO.: _____

ADMINISTRATOR : _____

Please check on the appropriate box. Do not leave blank boxes.

A. LOCATION	YES	NO	REMARK/S
1. Is the clinic located in a place with pleasant environment suitable for ambulatory clinics?			
2. Is the clinic free from undue noise, smoke, dust foul odour and flood?			
B. LOBBY	YES	NO	REMARK/S
1. Does the lobby have the following facilities:			
a. Well-designed reception/ Information counter			
b. Patient admitting/ waiting area			
c. Billing section			
2. Is the lobby reasonably furnished with seating facilities commensurate to the size of the clinic?			
C. GENERAL FACILITIES	YES	NO	REMARK/S
1. Signages			
a. Are there appropriate signage's conspicuously displayed In the clinic?			
2. Public Phones			
a. Are there public phones available?			
3. Medical/Dental Records Area			
a. Is there available medical/dental records of patients within the clinic?			
4. Patient Movement			
a. Is there adequate space for patient movement?			
5. Public Washrooms			
a. Is the clinic's public washroom/s clean and presentable?			
b. Is it provided with running water and toiletries?			

6. Parking a. Is there adequate and secured parking area available?			
7. Health, Safety and Security Policies a. Is the clinic entirely a non-smoking area?			
b. Does the clinic provide security in all entrances and exits of the clinic during operation hours?			
c. Is there a posted plan for evacuation in case of fire or other emergencies?			
d. Are fire exits free from obstruction?			
e. Does the clinic have fire extinguishers?			
f. Are the fire extinguishers checked regularly?			
g. Are fire alarms properly located?			
8. Facilities for the Disabled			
a. Does the clinic have facilities for the disabled?			
D. TREATMENT ROOMS	YES	NO	REMARK/S
1. Are the treatment rooms well-maintained and sanitized in accordance with DOH standards?			
2. Is the clinic provided with modern equipment and instruments?			
E. ENGINEERING AND MAINTENANCE	YES	NO	REMARK/S
1. Lighting and Ventilation a. Are there adequate lighting and ventilation in all areas of the clinic?			
2. Emergency Generator a. Is there a stand-by generator available to provide sufficient power in rooms, hallways, public areas, operating elevators, refrigeration and water services of the clinic?			
3. Waste Management a. Does the clinic provide 4 garbage receptacles for different types of wastes? (General - Non-Infectious - Dry, General-Non-Infectious - Wet, Infectious Waste and Sharps)			
b. Are they covered?			
c. Is fumigation regularly conducted in all areas of the clinic?			
d. Is there a regular garbage pick-up?			

F. STAFF	YES	NO	REMARK/S
1. Are staff professionally qualified, efficient and highly trained?			
2. Are staff in smart and clean uniforms			
3. Are the medical staffs licensed by PRC, PDA or PMA?			
G. PATIENT TRANSPORT VEHICLE			
1. Is there an available transportation services during operation hours?			
<p>This is to signify my intent to apply for DOT Accreditation.</p> <p>I understand that my Self-Assessment Rating is not yet final and an Audit Team from the DOT shall conduct an actual assessment of my property to validate my rating.</p> <p>_____</p> <p>SIGNATURE OVER PRINTED NAME OWNER/ GENERAL MANAGER</p> <p>_____</p> <p>DATE</p>			