MLSCN FORM A

MLSCN ACCREDITATION SERVICE

Federal Statutory Body established by Act 11 2003

PLOT 1166, MUHAMMAD N. UMAR LANE, DURUMI PHASE 11, ABUJA

MLSCN-AS Ref. No:											

APPLICATION FOR ACCREDITATION OF MEDICAL LABORATORY ENROLLMENT FORM

PART 1: GENERAL INFORMATION

MLSCN Criteria for Enrolment

- Participation in proficiency testing (PT) schemes or inter-laboratory comparisons
- Procedures/description of methods of tests
- Routine quality control for all test methods
- Evidence of internal audits conducted by laboratory
- Laboratory Quality manual

This form should be completed in full and returned with application fee to:

Medical Laboratory Science Council of Nigeria (MLSCN)
Attention: MLSCN Accreditation Service

Email: info@mlscn-as.org , labaccreditation@mlscn.gov.ng

Please complete ALL sections on the form and if any difficulties in completing the form, please contact MLSCN Accreditation Service (labaccreditation@mlscn.gov.ng; +234-0803-309-6407)

Please, if you wish to complete and forward the form by email; please note that MLSCN does not accept responsibility for breach of confidentiality of information or for the receipt of applications. **All applications submitted by email or by surface/special courier mail must be forwarded, duly signed.**

Receipt of payment of the application fee shall be required prior to processing the application.

Note: If you do not receive acknowledgement of receipt of your application from MLSCN or e-mail within Three (3) weeks of dispatch you should contact the MLSCN office directly. This application remains valid for one year from the date of application.

Applicant Laboratory Information

Application Date					
Institution Name					
Laboratory Name					
Type of Laboratory					
Level of Laboratory					
Laboratory Approval No. (MLSCN/PML No)					
Contact Person		**Title**			
Position					
Postal Address					
Physical Address					
Mobile No		**Tel No:**		**E-mail address**	

Application for:
(Tick as appropriate)

Initial Accreditation	☐	Extension of Accreditation *Proceed to complete*	☐
Other *(Please specify)* ☐			

Discipline
(Tick as appropriate)

Chemical Pathology		Haematology		Serology	
Molecular Diagnostic		Microbiology		Histopathology	
Immunology		Virology		Cytology	
Parasitology					
Other *(please specify Discipline)*					

ISO standard for which accreditation is sought

ISO 15189:2012		ISO/IEC 17025	

PART 2: INFORMATION REGARDING YOUR INSTITUTION

Description of the main activities of the applicant Institution *(Please underline those activities for which accreditation is sought):*

If the Institution seeking accreditation is owned by another Institution or is part of a larger Institution or has branches/divisions at other locations, please give the following details:

Name, address and contact information (Tel, E-mail) of:

Parent Institution	
Other institution in group/ division	
Branches at other locations	

Relationship and links between the above-mentioned institution and the institution seeking accreditation *(Please describe)*			
What is the legal status of your institution? e.g. Public (Private)/Ltd privately owned or other			
Registration Number of Company/ Identify Number(s) of sole owner or partners			
Total number of employees in the whole institution or group of institution		Number of employees involved in area(s) seeking accreditation	
Please attach an organizational chart of your institution indicating the structure of the sections/units/areas to be accredited and their relation to the rest of the organization.			
Has the institution ever been accredited before?	☐ Yes	☐ No	
If yes state name of accreditation body:			
Does the institution have an established formal management system?	☐ Yes	☐ No	
If yes state standard upon which system is based:			
How long has this system been in operation?			
What training has been provided for the implementation and maintenance of the system?			

To whom has the training been provided for?

Have you performed a self-evaluation using MLSCN Accreditation Service Checklist? Yes or No

If Yes, most recent score_____

In which Proficiency Testing (PT) Schemes/Inter-laboratory Comparisons do you or have you participated in?

Note: Participation in PT schemes or inter-laboratory comparisons is a prerequisite for accreditation.

Scheme Name	parameters	Frequency of Participation

Scheme Name	Parameters	Frequency of Participation

PART 3: INFORMATION ON LABORATORY MANAGEMENT CONTACTS

For each staff member having responsibility for a product or service for which accreditation is sought, please give the following details. This includes the Quality Manager and Technical Manager, as applicable.

Name		Title/ Position	
Section/Department /Unit of responsibility		No. of staff supervised	
Qualifications, Experience and Formal Training:			
Name		Title/ Position	
Section/ Department/ Unit of responsibility		No. of staff supervised	

Qualifications, Experience and Formal Training:

Name		Title/ Position	
Section/ Department/ Unit of responsibility		No. of staff supervised	

Qualifications, Experience and Formal training:

Name		Title/ Position	
Section/ Department/ Unit of responsibility		No. of staff supervised	

Qualifications, Experience and Formal Training:

Name		Title/ Position	
Section /Department/ Unit of responsibility		No. of staff supervised	

Qualifications, Experience and Formal Training:

Name		Position	
Section/ Department/ Unit of responsibility		No. of staff supervised	

Qualifications, Experience and Training:

PART 4: DECLARATION

Chief Executive Officer (CEO) or authorized official must authorize this form.

The following is enclosed *(please tick as appropriate)*

	Application Fee: Transfer order placed *(please attach banking information on transfer)*	

Other documentation **SEE NOTE 1***(Specify any attachment to the application form and/or tick below)*

NOTE 1 Documentation to be submitted prior to document review:	**Tick**

a) Duly completed Application Form

b) Quality Management System Manual

c) Information regarding active participation in PT schemes/Inter-laboratory Comparisons

d) Procedures/description of methods of tests

e) Procedure for validation of methods, an example of validation data

f) Signed MLSCN Accreditation Service Agreement

g) Evidence of Internal audits conducted by laboratory

h) Proposed assessment dates (for scope extensions only)

Note: Applications for scope extensions should be made six (6) weeks in advance prior to the scheduled assessment.

Upon accreditation, my institution agrees to comply with the MLSCN accreditation requirements and procedures.

I enclose a copy of the Quality Management System Manual.

I enclose an **application** fee. I understand that this fee is not refundable.

I understand the criteria in which the accreditation system operates and its functions. MLSCN does not accept any responsibility for the actions, or the results of any actions, of an accredited organization. I, the undersigned, agree, as the authorized officer of the applicant independent entity that any liability of MLSCN which may arise due to negligence related to any accreditation is limited to a refund of the annual fee payable by the institution.

I declare that the information given in this **application** is both correct and accurate to the best of my knowledge and belief. I undertake to inform MLSCN timely of any changes with respect to the application and accept full responsibility for any costs incurred as a result of any changes not reported to MLSCN timely.

Signed and stamped	
Name	
Position	
Date	