PROVIDER PROFILE FORM

- **Medical Director's Details:**

Name: ……

Medical School Attended:……

Qualification(s) with date(s):……

Professional Reg. No:……..

Specialty:……..

- **Administrator's Details:**

Name……..

Designation:……

Qualification(s) with date(s)……

- **Medical Facility Details :**

Kindly answer the following questions for the purpose of quality assurance (mark √ or answer when appropriate):

Clinic ☐ Hospital ☐ Specialist Services ☐ Radiology ☐ Pharmacy ☐ Laboratory ☐ Physiotherapy ☐ Mortuar y ☐

Others (please State): _____

Name of Facility:_____

Address:_____

Mobile phone:_____. Office Phone :_____

E-mail Address:_____Website:_____

Town:_____L.G.A:_____.State:_____

Year of incorporation:_____ CAC Registration No. _____

- **Type of Medical Practice:**

- ***Sole proprietorship*** ☐ ***Partnership*** ☐ ***Limited Liability Company*** ☐

  Name of proprietor(if sole Proprietary) ……

  Address: ……

  ……..……

- (Limited liability company): ……..

- Partnership

  Names of current partners.

  1. _____ Designation_____

2._____Designation_____

3._____Designation_____

4._____Designation_____

❖ Medical/Professional Credentials and details

Please attach the facility profile and relevant documents ,list of personnel & their qualifications along with the credentials of the following staff:

- Full time doctors
- Part time doctors
- Matron
- Two senior nursing staff
- Specialist (if available)

❖ **Bank Account Details:**

Name of Bank:……

Branch/Address:……

Account Name:……..

Account Number:……..

❖ **Professional Indemnity Cover** :

Insurance company providing the cover:……

Address:……..

……..

Tel:..... Email address:……

Amount: _____ Expiration date: _____

Policy Date: _____ _____Policy No: _____

_____ _____ _____

Name Signature Date

****Please attach duplicate copies of relevant documents****