|  |
| --- |
| ORGANISATION Details |
| Organisation Name*(i.e. name of the body taking legal responsibility for the activities of the service)* |   |
| UKAS Ref No. **(Existing Customers Only)** |   |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Standard |  |  |  |  |
| IQIPS |[ ]   | Imaging | [ ]  |

Scope(s) Requested:

| No | MODALITY FIELDS(activities) | TYPES OF EXAMINATION/TECHNICAL FIELDS/ACTIVITIES (please provide general header and listing of all activities etc.) | **description of key equipment used (Make and Model)** | LOCATION1 |
| --- | --- | --- | --- | --- |
| Example 1 | Audiology | Adult Hearing Assessment:OtoscopyPure Tone AudiometryTympanometry | Firefly Video otoscope  | MedtownCommunity Hospital |
| Example 2 | MRI | General MRIMusculoskeletal MRIMRI Reporting | MRI Scanner 1.5 T | Medtown General Hospital |
| 1 |   |   |   |   |
| 2 |   |   |   |   |
| 3 |   |   |   |   |
| 4 |   |   |   |   |
| 5 |   |   |   |   |
| 6 |   |   |   |   |
| 7 |   |   |   |   |
| 8 |   |   |   |   |
| 9 |   |   |   |   |
| 10 |   |   |   |   |
| 11 |   |   |   |   |
| 12 |   |   |   |   |
| 13 |   |   |   |   |
| 14 |   |   |   |   |
| 15 |   |   |   |   |
| 16 |   |   |   |   |
| 17 |   |   |   |   |
| 18 |   |   |   |   |
| 19 |   |   |   |   |
| 20 |   |   |   |   |
| 21 |   |   |   |   |
| 22 |   |   |   |   |
| 23 |   |   |   |   |
| 24 |   |   |   |   |
| 25 |   |   |   |   |

 ***1*** *Please indicate [with a ‘\*’] on the details above any tests / examinations / activities that you carry out at remote sites undertaken in other areas of the hospital, or in temporary or mobile facilities. Please also indicate the type of site (e.g. mobile facility) and locations.*

(To facilitate completion, the list of scopes requested can be documented on an accompanying spreadsheet or table)

|  |
| --- |
| Please identify ANY SPECIFIC ACTIVITIES WHICH SUPPORT THE FUNCTIONING OF THE SERVICE(E.g. facilities management, procurement, HR, advisory services, etc. together with their location) |
| Activity | Location |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

| Further information (COMPLETE FOR NEW APPLICATIONS, AND WHERE RELEVANT TO AN EXTENSION TO SCOPE) | YES | NO |
| --- | --- | --- |
| DO YOU PROVIDE A SERVICE FOR ANY SCREENING PROGRAMMES (e.g. antenatal, NEWBORN, cancer)?(if yes please provide details below)Click here to enter text. |[ ] [ ]
| do you offer /provide activities or examination procedures THE RESULTS OF WHICH could be used as evidence in the criminal justice system? (if yes please provide details below)Click here to enter text. |[ ] [ ]
| do STAFF PERFORM ANY EXAMINATION OR PRE-EXAMINATION ACTIVITIES OUTSIDE OF THE SERVICE SETTING? (if yes please provide details below)Click here to enter text. |[ ] [ ]

| DOES YOUR SERVICE CONDUCT ANY ACTIVITIES THAT YOU DO NOT WISH TO HAVE INCLUDED WITHIN THE SCOPE OF YOUR ACCREDITATION? (if yes please provide details below) [NEW APPLICANTS ONLY] |
| --- |
|   |

IN-HOUSE CALIBRATION:

Are there any in-house calibration(s) of equipment used for any activities included in your scope of application?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Yes** | [ ]  |  | **No** | [ ]  |

*If ‘Yes’ please provide details below (refer to UKAS publication* ***TPS 41*** *for information)*

| No. | MEASURED INSTRUMENT | reference standard used | PROCEDURE | PURPOSE(details of measurement activities that this supports) |
| --- | --- | --- | --- | --- |
| 1 |   |   |   |   |
| 2 |   |   |   |   |
| 3 |   |   |   |   |
| 4 |   |   |   |   |
| 5 |   |   |   |   |
| 6 |   |   |   |   |

**MULTI-SITE APPLICATIONS:**

If your application covers activities performed at more than one site, details must be provided below. If this is an *extension to scope* application, please indicate if the application affects the current listing as identified on the first page of your schedule of accreditation.

| **Site No.** | **site location** | activities performed at this site2 | description of key equipment used  | contact details |
| --- | --- | --- | --- | --- |
| Example | Medtown Health Centre | Hearing Assessment:Otoscopy, Pure tone audiometry | Firefly Video otoscope,  | DR A, ATOWN SITE, PHONE XXXXXX |
| 1 |   |   |   |   |
| 2 |   |   |   |   |
| 3 |   |   |   |   |
| 4 |   |   |   |   |
| 5 |   |   |   |   |

*Add further lines as needed*

**2***Please use the same terms as referred to in the first two columns of the first table used in this form*

**EXTENSIONS TO SCOPE ONLY:**

Please note the following:

* Please complete previous tables as relevant to the scope of the extension
* To enable an effective review of this application, evidence to support the inclusion of this extension into the existing Quality Management system will be requested by the Assessment Manager

1. [ ]  I wish this extension to scope application to be processed now (and understand this may require an extra visit by UKAS).

**Desired target grant date:** Click or tap to enter a date.

(If this field is left blank, a default of 6 months from the date this application is processed will be assigned as the desired grant date)

**Desired assessment arrangements:** Select from drop-down list

(Please note standard *minimum* UKAS timeframe for the assessment of extensions to scope *is 3 months from receipt of application*, and your Assessment Manager will discuss if your chosen option doesn’t fit in with your desired grant date or if your desired grant date isn’t possible)

2. [ ]  I wish this extension to scope application to be processed with my next surveillance/re-assessment visit.

3. [ ]  I would like to propose that this extension to scope application is considered for desktop review

*(Please note that the decision on the applicability of this proposal will be made by UKAS based on a number of factors including existing scope of accreditation and competences demonstrated)*

Declaration:

* I declare that I am authorised, on behalf of the organisation, to submit this application, and that the information contained herein is both correct and accurate to the best of my knowledge and belief.
* By submitting this application, I acknowledge that I have read, understood and accepted UKAS’ [**Standard Terms of Business**](https://www.ukas.com/).
* If this application relates to an extension to scope, I understand and accept that:
	+ An initial charge of 0.5 days at the standard day rate will apply to cover scoping of effort required
		- *This will not result in any additional charge to customers who proceed within 12 months of application. If a customer takes no action to progress an extension to scope application over a period of a year with no mitigating circumstances, UKAS reserves the right to withdraw the application. The initial charge is not refundable as it covers work already undertaken. Once an application is withdrawn, if the customer subsequently wishes to progress the extension to scope, they will need to reapply.*
	+ It may be necessary to revise our annual fees upon grant of the extension to scope

|  |  |
| --- | --- |
| **Name:** | Click here to enter text. |
| **Position:** | Click here to enter text. |
| **Date:** | Click here to enter a date. |

Applications to be Submitted To:

**EMAIL**:**apps@ukas.com**

**POST**: **Applications Unit, United Kingdom Accreditation Service, 2 Pine Trees, Chertsey Lane, Staines-upon-Thames, TW18 3HR**