



KIBABII UNIVERSITY

PREQUALIFICATION OF SUPPLIERS: - HEALTH SERVICES PROVIDERS

SPECIALISTS NAME:

CATEGORY NO: PREQ/KIBU/03/2020-2022

CATEGORY DESCRIPTION: PROVISION OF HEALTH SERVICES: - SPECIALISTS

TO:

KIBABII UNIVERSITY

TEL NO: 0734 831 729 or 0708 085 934

EMAIL: tenders@kibu.ac.ke

WEBSITE: www.kibu.ac.ke

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SECTION I- INVITATION FOR PREQUALIFICATION

Kibabii University intends to prequalify health service providers. Interested eligible providers (Hospitals and Specialists) are invited to apply for prequalification.

1.2 Documents containing detailed instructions and requirements may be downloaded from the Kibabii University website www.kibu.ac.ke free of charge. Applicants who download the prequalification document **MUST** email their names, contact details and tender number to: tenders@kibu.ac.ke

Completed registration documents in a plain sealed envelope, clearly marked “**PREQUALIFICATION OF HEALTH SERVICE PROVIDERS**” and bearing the respective **REFERENCE NUMBER & CATEGORY** but no indication of the applicants’ name, should be deposited in the Tender Box at the **University Administration Entrance** or sent by post to

**The Vice Chancellor
Kibabii University
P.O. Box 1699 – 50200
BUNGOMA**

So as to be received on or before Thursday **17th September, 2020 at 10:00 am**
PROCUREMENT OFFICER
For: VICE CHANCELLOR, KIBABII UNIVERSITY

SECTION II – INSTRUCTION TO APPLICANTS

2.1 Introduction

Kibabii University referred to as the procuring entity intends to prequalify suppliers for health service provider and medical specialist

2.1.2 Prequalification is open to eligible medical specialists private hospitals and level four (4) and above government hospitals as indicated in appendix instruction to applicants. Provider registered with Registrar of companies under the laws of Kenya in respective services are invited to submit their Prequalification documents to the Vice Chancellor Kibabii University so that they may be Prequalified for provision of medical services.

2.1.3 Prospective providers must have carried out successful delivery of similar services to Government/Corporate/institutions of similar size. Potential provider must demonstrate the willingness and commitment to meet the Prequalification criteria.

2.2 Submission of application

2.2.1 Applications for Prequalification shall be submitted in a sealed envelope marked with the category name and reference number and deposited in the Tender Box located at the Administration Block, Kibabii University Main Campus OR be addressed and posted to:

**The Vice Chancellor
Kibabii University
P.O. Box 1699 – 50200
BUNGOMA**

So as to be received on or before **Thursday 17th September, 2020 at 10:00 am**

2.2.2 The tender prepared by the tenderer, as well as all correspondence and documents relating to the tender, exchanged by the tenderer and the Procuring entity, shall be written in English language. Any printed literature furnished by the tenderer may be written in another language provided they are accompanied by an accurate English translation of the relevant passages in which case, for purposes of interpretation of the tender, the English translation shall govern.

2.3 Eligibility of applicants

2.3.1 This invitation for Prequalification is open to all candidates who are eligible as defined in the Kenya Public Procurement Law and regulations.

2.3.2 The Kibabii University employees, committee members, board members and their relatives' (spouse and children) are not eligible to participate.

2.3.3 Any public owned sector or hospital may be eligible to qualify if in addition to meeting all the above requirements, it is also legally and financially autonomous, it operates under commercial law, and it is not a dependent agency of another public entity

2.4 Qualification Criteria

2.4.1 The attached questionnaire forms described are to be completed by prospective providers who wish to be Prequalified for submission of tender for health service

2.4.2 The Prequalification application forms which are not filled out completely and submitted in the prescribed manners will not be considered. All the documents that form part of the proposal must be written in English and indelible.

2.4.3 **The audited accounts:** The supplier's financial condition will be determined by the last two years audited financial statement submitted with the application documents as well as letters of reference from previous performances. Potential providers will be prequalified on the satisfactory information given.

Special consideration will be given to the financial resources available as working capital, taking into account the amount of uncompleted orders on contract and now in progress. Potential bidders shall provide evidence to execute the contract.

2.4.5 **Litigation history:** the applicant should provide accurate information about ligation or arbitration resulting from contracts completed or uncompleted under its execution.

2.4.6 **Past Performance:** will be given due consideration in Prequalification of suppliers.

2.4.7 **Statement:** Application must include a sworn statement by the provider ensuring the accuracy of the information given.

- 2.4.8 Withdrawal of Prequalification:** Should a condition arise between the time the firm is applying to Prequalify and the bid opening date which could substantially change the performance and qualification of the bidder or the ability to perform such as but not limited to bankruptcy, change of ownership or new commitments, the Kibabii University reserves the right to reject the tender from such a bidder even though they have been initially Prequalification
- 2.4.9 Business premises:** The firm must have a fixed Business premise and must be registered in Kenya with certificate of Registration, Incorporation/Memorandum and articles of Association. Copies must be attached.
- 2.4.10** The firm must show proof that it has paid all its statutory obligations and have a Valid Tax Compliance Certificate.

SECTION III: APPLICATION FORMS.

Form I LETTER OF PREQUALIFICATION

Prequalification category Ref: No PREQ/KIBU/03/2020-2022

**To: The Vice Chancellor
Kibabii University
P.O. Box 1699 – 50200
BUNGOMA**

Dear Sir:

1. Having examined the application documents including of which is hereby duly acknowledged, we the undersigned, offer to provide health services to Kibabii University staff, staff dependent and students and as may otherwise be directed.
2. We undertake if our application is acceptable to provide health service in accordance with the delivery schedule in the schedule of requirement or official order signed by authorized officer/s of the University.
3. We agree to abide by this application for the period of processing the applications and prepared and executed, this application together with written acceptance thereof shall constitute a binding agreement between us.
4. We understand
 - a. That this is an application for consideration to be Prequalified as a Kibabii University provider of health service, during the period between the year **2020 -2022**
 - b. That you are not bound to accept this application or any other that you may receive.
5. We have attached to this application copies of original documents of:
 - a) Registration/ incorporation certificate
 - b) PIN Certificate
 - c) VAT Certificate
 - d) Valid tax compliance certificate
 - e) Registration certificate with Professional Body
 - f) Specialist practicing license

We make this application with full understanding that:

- i. Bids by Prequalification applicants will be subject to verification of all information submitted.
- ii. Kibabii university reserves the right to accept or reject any application, cancel the Prequalification process and reject all applications

The undersigned declare that the statements made and the information provided in the duly completed application are complete made, true and correct in every detail.

Sign and stamp

Witnessed by

Designation

Date

Form II: PROCLAMATION /SWORN STATEMENT/DECLARATION

I/We the undersigned, state that, ALL the information we have given provided in this document is correct/accurate to the best of our knowledge and that I/We give Kibabii University authority to seek any reference it may deem vital while carrying out their evaluation. I/We also hereby declare that the company is not debarred from participating in any public procurement proceeding.

Name of applicant.....Designation.....Signature.....

Witnessed by.....Designation.....Signature.....

Official rubber stamp

State if you have any relationship with Kibabii University employee (which relationship)

.....
.....

Information submitted by.....

Title.....

Signature

Stamp.....

KIBABII UNIVERSITY

PREQUALIFICATION OF EYE SERVICES FORM

NAME OF SPECIALIST: PROF/DR/MR/MS _____

NAME OF HEALTH FACILITY (if any) _____

QUALIFICATIONS: MBChB (OPT&CAT.SUR) _____ BS.OPTO _____ OPHT.CO _____ (tick)

PROFESSIONAL REGISTRATION NO: _____

PRACTICING LICENSE NO. _____

A. Policies		Assessment		Comments
i	The facility has in place a policy to identify, diagnose, interpreted and manage eye related problems	Y <input type="checkbox"/>	N <input type="checkbox"/>	
ii	Procurement, storage, requisition, dispensing before expiry, Labeling, installation, maintenance, administration & disposal of Ophthalmology medication, materials, equipment & instruments in line with International standards and manufacturers Guidelines.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
B. Equipment				
Basic Diagnostic equipment				
iii	Eye Chart (Snellen's chart)	Y <input type="checkbox"/>	N <input type="checkbox"/>	
iv	Slit Lamp	Y <input type="checkbox"/>	N <input type="checkbox"/>	
v	Direct Ophthalmoscope	Y <input type="checkbox"/>	N <input type="checkbox"/>	
vi	Tonometer	Y <input type="checkbox"/>	N <input type="checkbox"/>	
vii	Refraction Set	Y <input type="checkbox"/>	N <input type="checkbox"/>	
viii	Pen Torch	Y <input type="checkbox"/>	N <input type="checkbox"/>	
ix	Retinoscope	Y <input type="checkbox"/>	N <input type="checkbox"/>	
x	Indirect Ophthalmoscope	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xi	Applanation	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xii	Tonopen	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xiii	Lenses(20D,78D,90D)	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xiv	3 Mirror Lens	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xv	Visual Perimetry apparatus	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xvi	Ophthalmic Operating Microscope	Y <input type="checkbox"/>	N <input type="checkbox"/>	

Hospital Representative Names _____ Signature _____ Date _____

C. Basic Surgical Equipment		Assessment		Comments
xvii	Keratometer	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xviii	A-Scan	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xix	Operating Instrument Sets,	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xx	Basic Anterior Segment Set (Cataract And Glaucoma), Lid surgery, Squint, Orbital surgery , Vitreoretinal surgery	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxi	Operating room space,	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxii	Ophthalmic Operating table and chair, trolley, drip stand,	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxiii	sterilization equipment	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxiv	Anterior Vitrector	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxv	Paediatric(Vitrector Machines , Keratomiter,)	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxvi	Corneal Grafting Instruments	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxvii	Glaucoma(Glaucoma Laser Lenses, Puchymeter)	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxviii	Vitrio Retinal (Endo Laser, Posterior Vitrectomy Machine,	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxix	Orbital and Oculloplastic surgery equipment)	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxx	Refractive Surgery equipment	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxi	Corneal Topography	Y <input type="checkbox"/>	N <input type="checkbox"/>	
D. Consumables		Assessment		Comments
xxxii	Local anesthetic solution and needles.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxiii	Sterile gauze.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxiv	Disposable gloves.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxv	Disposable face masks.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxvi	Cotton rolls.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxvii	Medical gasses and compressors are Provided for in a safe manner.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxviii	Policies, procedures and guidelines in place and in use as regards	Y <input type="checkbox"/>	N <input type="checkbox"/>	
TOTAL 76 (In this Section Yes has a value equivalent of 2)				

SECTION C: FOR OFFICIAL USE ONLY: FINDINGS AND RECOMMENDATIONS

KIBU ASSESSMENT TEAM

Name	Designation	Signature
FACILITY REPRESENTATIVE(S)		

DECLARATION

We.....and of
 (Facility)

Certify that the information provided reflects the true status of the facility and that we shall take full Responsibility of any variations herein provided.

Signature (1).....Signature (2).....

OFFICIAL STAMP

KIBABII UNIVERSITY

PREQUALIFICATION OF DENTAL SERVICES FORM

NAME OF SPECIALIST: PROF/DR/MR/MS _____

NAME OF HEALTH FACILITY (if any) _____

QUALIFICATIONS: DDS _____ DMD _____ DENTAL.TCH. _____ (tick)

PROFESSIONAL REGISTRATION NO: _____

PRACTICING LICENSE NO. _____

A. Infrastructure		Assessment		Comments
i	An area or a room has been set aside for dental services.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
ii	There are guidelines available on diagnosis, interpretation of Various dental conditions.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
B. Equipment and Tools for Dental Healthcare Services		Assessment		Comments
iii	There is a policy in place for acquisition, usage, calibration, Maintenance, storage and disposal of equipment in the facility.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
iv	Available or access to an OPG machine	Y <input type="checkbox"/>	N <input type="checkbox"/>	
v	Dental Chair and unit in functional state.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
vi	Operators chair and assistants' chair.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
vii	Compressor.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
viii	Suction machine.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
ix	Autoclave.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
x	Amalgamator.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xi	Light cure machine.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xii	Intra-oral x-ray machine.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xiii	Ultrasonic scalar.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xiv	High speed and slow speed hand pieces.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xv	Examination light.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xvi	Mouthwash.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xvii	Lockable Instrument cabinets.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xviii	Disposable bins with foot control (Plastic or Metallic).	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xix	Amalgam filter.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xx	Working Refrigerator.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxi	Emergency tray i.e. (Disposable syringes, adrenaline, Hydrocortisone, IV cannulas etc).	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxii	Full set of extraction forceps and elevators.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxiii	Dental syringes.	Y <input type="checkbox"/>	N <input type="checkbox"/>	

Hospital Representative Names _____ Signature _____ Date _____

Equipment And Tools For Dental Healthcare Services		Self Assessment		Comments
xxiv	Amalgam restoration tray i.e. (Amalgam carrier, Amalgam Condenser, Curver, Burnisher, Matrix holder and bands, Wedges, Calcium Hydroxide applicator, Carie excavator & Rotary burs). <i>*Tick Yes if all tools are available in the tray and No if any is missing</i>	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxv	Composite restoration tray i.e. (Caries, excavator, Cement applicator, Enamel/Dentine Bonding agent, Acid etch set, Composite resin, Mylar strips, Composite polishing strips, Plastic applicators & Rotary burs). <i>*Tick Yes if all tools are available in the tray and No if any is missing</i>	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxvi	Endodontic tray- either rotary or hand instruments i.e. (Reamers and Files, Barbed Broaches, Gutter percha condenser, Gutta percha, Paper points, Root canal Disinfectant, Root canal Obturation Cement). <i>*Tick Yes if all tools are available in the tray and No if any is missing</i>	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxvii	Diagnostic tray i.e. (Mirror, Probe, Tweezers, Periodontal probe, Cotton rolls & Vitality test kit). <i>*Tick Yes if all tools are available in the tray and No if any is missing</i>	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxviii i	Assorted impression trays i.e. (Upper edentulous, Lower edentulous, Lower dentate (No. 1-3), Upper dentate (No. 1-3), Paedo trays (upper and lower) & Impression material). <i>*Tick Yes if all tools are available in the tray and No if any is missing</i>	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxix	Surgical tray includes all the following: Periosteal elevator, Blade holder and blades, Tissue forceps Needle holder, Sutures, Surgical scissors, High speed evacuation tips, Lower molar forceps, Upper molar forceps (left and right), Lower premolar forceps, Lower anterior forceps, Lower root forceps, Upper anterior forceps, Upper root forceps, Criars elevator (left and right), Straight elevators (No. 1,2 and 3), Root tip elevator (left and right). <i>*Tick Yes if all tools are available in the tray and No if any is missing</i>	Y <input type="checkbox"/>	N <input type="checkbox"/>	

Hospital Representative Names _____ Signature _____ Date _____

C. Policies and Guidelines:		Assessment		Comments
xxx	Policies, procedures and guidelines in place and in use as regards procurement, storage, requisition, dispensing before expiry, labeling, installation, maintenance, administration & disposal of dental medication, materials, equipment & instruments in line With International standards and manufacturers guidelines.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxii	There are policies and procedures in place to govern the Management of dental materials.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxiii	Infection prevention and control policies in place and used.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxiii	Appropriate staff in place in the unit.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
D. Records Keeping		Assessment		Comments
xxxiv	There is a register available to show services and dental Procedures carried out.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxv	A well-kept register which is maintained for all services Available.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
E. Dental X-Ray and Imaging		Assessment		Comments
xxxvi	There is a policy in place for acquisition, usage, calibration, Maintenance, storage and disposal of equipment in the facility.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxvii	Policies, procedures and guidelines in place and in use as regards procurement, storage, requisition, dispensing before expiry, labeling, installation, maintenance, administration & disposal of dental radiographic materials equipment& instruments in line with International standards and Radiation Protection Board Guidelines.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxviii	There are policies and procedures into govern the management Of dental materials.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
TOTAL 76 (In this Section Yes has a value equivalent of 2)				

Hospital Representative Names _____ Signature _____ Date _____

SECTION C: FOR OFFICIAL USE ONLY: FINDINGS AND RECOMMENDATIONS

KIBU ASSESSMENT TEAM

Name	Designation	Signature
FACILITY REPRESENTATIVE(S)		

FACILITY DECLARATION

We.....andof
 (Facility)

Certify that the information provided reflects the true status of the facility and that we shall take full Responsibility of any variations herein provided.

Signature (1).....Signature (2).....

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KIBABII UNIVERSITY

PREQUALIFICATION OF OTHER MEDICAL AND SURGICAL SPECIALISTS FORM

NAME OF SPECIALIST: PROF/DR./MR./MS _____

AREA OF SPECIALIZATION _____

NAME OF HEALTH FACILITY (if any) _____

QUALIFICATIONS: _____

PROFESSIONAL REGISTRATION NO: _____

PRACTICING LICENSE NO. _____

FOR OFFICIAL USE ONLY: FINDINGS AND RECOMMENDATIONS		
KIBU ASSESSMENT TEAM		
Name	Designation	Signature
FACILITY REPRESENTATIVE(S)		

DECLARATION

We.....and of
..... (Facility)

Certify that the information provided reflects the true status of the facility and that we shall take full Responsibility of any variations herein provided.

Signature (1).....Signature (2).....

OFFICIAL STAMP

i. .

Mandatory requirement for specialists

	Requirements	Attached or not	Remarks
I	Company registration certificate (registration certificate/certificate of incorporation)		
ii.	VAT/PIN Registration certificate		
iii	Valid trading license/permit		
iv	Current/Valid tax compliance certificate		
v	Availability of physical Office(evaluation team may visit to confirm)		
vi	Dully filled health facility check list for respective specialists		
vii	Registration certificate with Professional Body		
viii	Specialist practicing license		

NOTE: All copies of the above Documents MUST be attached for the specialist to be pre-qualified.