PaGaKa Form (A)

Private General Clinic Business

1. Applicant's Name _____

2. Citizen's Scrutinizing Card No. _____

3. Name of the Clinic(if any) _____

4. Address of the Clinic _____

5. Land Area of the Clinic (Length x Width) (describe in Feet/Acre)_____

_____

6. Area of the Clinic (Length x Width x Height) (describe in Feet)_____

_____

7. Formation of clinic structure, rooms and areas (Attach with separate sheet)

8. Photos of present formation of Clinic (East, Side and Inside) _____

9. Preparation for Medical Records Yes./No. _____

10. Source of Drinking Water and Utility Water (Artesian Well ı City Water Supply, etc.)

_____

11. Enough source of water Yes./No. (Average available water gallon per day) _____

_____

12. Sewage System (Flushed Toilet, Drain Toilet) _____

_____

13. 24 Hours Electricity Availability Yes./No. (Arrangement)_____

14. Garbage management system Yes./No. (e.g – Burning Machine, City Development Arrangement and other arrangements)

_____

15. Arrangement for the Patients

	Yes.	No.
(a) Reception Area	☐	☐
(b) Waiting Area	☐	☐
(c) Examination room	☐	☐
(d) Injection/Pharmacy room	☐	☐

16. Patient Referral System Arrangement ☐ ☐

(If Yes, attach the Referral Form)

17. Availability of other Diagnostic Activities ☐ ☐

(If Yes, apply separately)

18. Storage system of Medicines and Medical Appliances (Describe with Photos)_____

19. Arrangements of Emergency Medicines Yes./No._____

20. Challan No. and Date for Payment of License Fee _____

21. Recommendation of City Development Committee Yes./No. _____

(If Yes, attach herewith)

22. Receive Prior Permission Yes./No. _____

23. Previously Operated Yes./No. (if Yes.)_____

Month/Year of Opening _____

Approved Organization/ Evidence _____

Expiry Date _____

24. Fire Safety System Yes./No. _____

(If Yes, submit the prevention arrangement)

25. Sterilization System Yes./No. _____

26. Responsible Personnel at the Clinic _____

(a) Name of Clinic Responsible Person _____

_____

(b) Specialists ( ) No.

(c) Medical Officers ( ) No.

(d) Nurses/Midwives ( ) No.

(e) Para–medic ( ) No.

(To fill the personal information at the CV Form for each and every person.)

27. Please describe any additional information _____

_____

_____

_____

Signature of Applicant: _____

Name:_____

Contact Telephone:_____