PaGaKa Form (B)

Private Specialist 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. Available Therapeutic Specialties:

   (a) ____

   (b) ____

   (c) ____

   (d) ____

   (e) ____

   (f) ____

   (g) ____

10. Preparation for Medical Records Yes./No. __________________________________

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11. Source of Drinking Water and Utility Water (Artesian Well ၊ City Water Supply, etc.)

____

12. Enough source of water Yes./No. (Average available water gallon per day) ________

____

13. Sewage System (Flushed Toilet, Drain Toilet) ________________________________

____

14. 24 Hours Electricity Availability Yes./No. (Arrangement)_________________________

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

		Yes.	No.
16.	Arrangement for the Patients		
	(a) Reception Area	☐	☐
	(b) Waiting Area	☐	☐
	(c) Examination room	☐	☐
	(d) Injection/Pharmacy room	☐	☐
17.	Patient Referral System Arrangement (If Yes, attach the Referral Form)	☐	☐
18.	Availability of other Diagnostic Activities (If Yes, apply separately)	☐	☐

19. Storage system of Medicines and Medical Appliances (Describe with Photos)_______

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

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

    (If Yes, attach herewith)

22. Receive Prior Permission Yes./No. _______________________________________

23. Clinic 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 ___________________________________

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Signature of Applicant: ____________________________

Name:____________________________

Contact Telephone:____________________________