PaGaKa Form (D)

Private Specialist Hospital Business

1. Applicant's Name _____
2. Citizen's Scrutinizing Card No. _____
3. Name of the Hospital _____
4. No. of Beds at present _____
5. Address of the Hospital _____
6. The number and distance of the nearest buildings around the Hospital _____

_____

_____

7. Land ownership document of the Hospital _____
8. Land Area of the Hospital (Length x Width) (describe in Feet/Acre)_____

_____

9. Area of the Hospital (Length x Width x Height) (describe in Feet) _____

_____

10. Arrangements of Ups and Downs (Type of Stairs) _____
11. Formation of Hospital's structure, rooms and areas (Attach with separate sheet) (Length x Width x Height) (describe in Feet)
    - in–patient Unit _____
    - Operation Theatre _____
    - Delivery Unit _____
    - Laboratory _____
    - Radiology Unit _____

– Intensive Care Unit _____

– Facilities for ICU Yes./No._____

(If Yes, provide name of equipment, quantity, whether useable or not with separate sheet.)

12. Available Therapeutic Specialties (If required submit separately):

(a) _____

(b) _____

(c) _____

(d) _____

(e) _____

(f) _____

(g) _____

13. Availability of Special Room Yes./No. _____

14. Available Basic and Advanced Hospital Equipment and Machines

(a) Basic Hospital Equipment and Machines

_____

_____

_____

_____

_____

(If the space is not enough, attach with separate sheet)

(b) Advanced Hospital Equipment and Machines

_____

_____

_____

_____

_____

(If the space is not enough, attach with separate sheet)

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

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

_____

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

_____

18. 24 Hours Electricity Availability Yes./No. (Arrangement)_____

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

_____

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

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21. Blood infusion arrangement for the Patients (Yes./No.) _____

If Yes, the arrangement _____

_____

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22. Arrangement for the Patients

    (a) Reception Area _____

    (b) Waiting Area _____

    (c) Examination room _____

    (d) Injection/Pharmacy room _____

    (e) Inpatient Units (distance between patient's beds)(Describe in Feet) _____

    _____

    (f) Arrangement for the dead body when the patient dead _____

23. Patient Referral System Arrangement (Ambulance Yes./No.) _____

    (If Yes, attach the Referral Form)

24. 24 hours Duty Assignment (Yes./No.) _____

    (If Yes, attach the Duty Roaster for Doctors and staffs)

25. Availability of other Diagnostic Activities

    (If Yes, apply separately)

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

27. Pharmacy Shop available at Hospital Yes./No._____

    (If Yes, is there a License issued by the Township Food and Drugs Administration)

28. Arrangements for Emergency Medicines _____

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

30. Recommendation of City Development Committee for the Building Yes./No._____

    (If Yes, attach herewith)

31. Receive Prior Permission Yes./No. _____

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

    Month/Year of Opening _____

    Approved Organization/ Evidence _____

    Expiry Date _____

33. Fire Safety System Yes./No. _____

    (If Yes, submit the prevention arrangement)

34. Responsible Personnel at the Hospital _____

    (a) Name of Responsible Person _____

    (b) Name of Chief/Head Physician _____

    (c) Specialists ( ) No.

    (d) Medical Officers ( ) No.

    (e) Nurses/Midwives ( ) No.

    (f) Para–medic ( ) No.

    (g) Other Staff ( ) No.

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

35. Please describe any additional information _____

    _____

    _____

    _____

    _____

_____

_____

Signature of Applicant: _____

Name:_____

Contact Telephone:_____