

Private Maternity Clinic Business

1. Applicant's Name _____
 2. Citizen's Scrutinizing Card No. _____
 3. Name of the Maternity Clinic and Address _____

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

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

 6. Preparation for Medical Records Yes./No. _____
 7. Source of Drinking Water and Utility Water (Artesian Well | City Water Supply, etc.)

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

 9. 24 Hours Electricity Availability Yes./No. (Arrangement) _____
 10. Sewage System (Flushed Toilet, Drain Toilet) _____

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

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12. Arrangement for the Patients

- (a) Reception Area _____
- (b) Waiting Area _____
- (c) Examination room _____
- (d) Privacy for Patients _____
- (e) Specific place for injection/medication _____
- (f) Complete facility for Delivery Room _____
- (g) Availability of Sterilization System _____

13. Patient Referral System Arrangement

(If Yes, attach the Referral Form)

14. Arrangement for Emergency Operation (Describe separately)

15. Availability of other Diagnostic Activities

(If Yes, apply separately)

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

17. Pharmacy Shop available at the Maternity Clinic Yes./No. _____

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

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

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

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

(If Yes, attach herewith)

21. Receive Prior Permission Yes./No. _____

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

Month/Year of Opening _____

Approved Organization/ Evidence _____

Expiry Date _____

23. Fire Safety System Yes./No. _____

(If Yes, submit the prevention arrangement)

24. Responsible Personnel at the Clinic _____

(a) Name of Maternity Clinic Responsible Person _____

(b) Name of Chief/Head Physician (If any) () No.

(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.)

25. Please describe any additional information _____

PaGaKa Form (E)

Signature of Applicant: _____

Name: _____

Contact Telephone: _____
