

Private Diagnosis Business (X' Ray)

1. Applicant's Name \_\_\_\_\_
2. Citizen's Scrutinizing Card No. \_\_\_\_\_
3. Name of the Business and Address \_\_\_\_\_  
\_\_\_\_\_
4. Land Area of the Business (Length x Width) (describe in Feet/Acre) \_\_\_\_\_  
\_\_\_\_\_
5. Area of the Business (Length x Width x Height) (describe in Feet) \_\_\_\_\_  
\_\_\_\_\_
6. Formation of structure, rooms and areas of the Business (Attach with separate sheet)(Length x Width x Height) (describe in Feet)
7. The Wall Thickness of the X' Ray Room \_\_\_\_\_ inch
8. Lead Glass, Lead Shield Yes./No. \_\_\_\_\_
9. Available X' Ray Examination \_\_\_\_\_
10. Preparation for Medical Records Yes./No. \_\_\_\_\_
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. 24 Hours Electricity Availability Yes./No. (Arrangement) \_\_\_\_\_
14. Sewage System (Flushed Toilet, Drain Toilet) \_\_\_\_\_

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

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16. Arrangement for the Patients

- (a) Reception Area \_\_\_\_\_
- (b) Waiting Area \_\_\_\_\_
- (c) Privacy for Patients \_\_\_\_\_
- (d) Changing Room for Patient \_\_\_\_\_

17. Information about the Imaging Machine

(a) Type of X' Ray Machine, Quantity

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_
- (3) \_\_\_\_\_
- (4) \_\_\_\_\_
- (5) \_\_\_\_\_

(b) Other Diagnosis Imaging Machines

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_
- (3) \_\_\_\_\_
- (4) \_\_\_\_\_

(5) \_\_\_\_\_

18. Availability of other Diagnostic Activities

(If Yes, apply separately)

19. Arrangements of Emergency Medicines Yes./No. \_\_\_\_\_

20. Planning for Radiation Safety Yes./No. \_\_\_\_\_

21. Plan for the protection from radiation for the staff assigned at the X' Ray Room  
Yes./No. \_\_\_\_\_

22. Challan No. and Date for Payment of License Fee \_\_\_\_\_

23. Recommendation of City Development Committee for the Building Yes./No. \_\_\_\_\_

(If Yes, attach herewith)

24. Receive Prior Permission Yes./No. \_\_\_\_\_

25. Previously Operated Yes./No. (if Yes.) \_\_\_\_\_

Month/Year of Opening \_\_\_\_\_

Approved Organization/ Evidence \_\_\_\_\_

Expiry Date \_\_\_\_\_

26. Fire Safety System Yes./No. \_\_\_\_\_

(If Yes, submit the prevention arrangement)

27. Responsible Personnel at the Laboratory \_\_\_\_\_

(a) Name of Responsible Person \_\_\_\_\_

(b) Specialists (Radiologist) ( ) No.

(c) Medical Doctors ( ) No.

**PaGaKa Form (G)**

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|----------------------|----------------|-----|
| (d) Nurses           | (            ) | No. |
| (e) Radiology Expert | (            ) | No. |
| (f) Other Staff      | (            ) | No. |

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

28. Please describe any additional information

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Signature of Applicant: \_\_\_\_\_  
Name: \_\_\_\_\_  
Contact Telephone: \_\_\_\_\_