PaGaKa Form (K)

Private General Health Care Service

1. Applicant's Name _____
2. Citizen's Scrutinizing Card No. _____
3. Name of the Business and Address _____
4. Land Area of the Clinic (Length x Width x Area) (describe in Feet/ Acre)_____
5. Area of the Business Building (Length x Width x Height) (describe in Feet)_____
6. Formation of Business rooms' structure and areas (Attach with separate sheet)
7. List of businesses to be carried out and the required equipment for each and every business (to be attached)_____
8. Arrangement for Medical Records Yes./No. _____
9. Source of Drinking Water and Utility Water (Artesian Well ı City Water Supply, etc.)

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

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

    _____
12. 24 Hours Electricity Availability Yes./No. (Arrangement)_____
13. Garbage management system Yes./No. (e.g – Burning Machine, City Development Arrangement and other arrangements)

    _____

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

17. Storage system of Medicines, Medical Appliances and machine, equipment for business use _____

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

19. Sterilization System Yes./No. _____

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

21. Recommendation for the building by the City Development Committee for the 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 fire prevention arrangement)

25. Responsible Personnel at the Business _____

(a) Name of Responsible Person of the Business _____

(b) Specialists ( ) No.

(c) Medical Officers ( ) No.

(d) Nurses ( ) No.

(e) Nurse Aid ( ) No.

(f) Other Staff ( ) No.

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

26. Please describe any additional information _____

_____

_____

_____

Signature of Applicant: _____

Name:_____

Contact Telephone:_____