

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

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

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

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

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PaGaKa Form (A)

- | | Yes. | No. |
|--|--------------------------|--------------------------|
| 15. Arrangement for the Patients | | |
| (a) Reception Area | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Waiting Area | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Examination room | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Injection/Pharmacy room | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Patient Referral System Arrangement | <input type="checkbox"/> | <input type="checkbox"/> |
| (If Yes, attach the Referral Form) | | |
| 17. Availability of other Diagnostic Activities | <input type="checkbox"/> | <input type="checkbox"/> |
| (If Yes, apply separately) | | |
| 18. Storage system of Medicines and Medical Appliances (Describe with Photos)_____ | | |
| 19. Arrangements of Emergency Medicines Yes./No. _____ | | |
| 20. Challan No. and Date for Payment of License Fee _____ | | |
| 21. Recommendation of City Development Committee 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. _____ | | |
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(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 _____

Signature of Applicant: _____

Name: _____

Contact Telephone: _____
