

Private Specialist 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. Available Therapeutic Specialties:
 - (a) _____
 - (b) _____
 - (c) _____
 - (d) _____
 - (e) _____
 - (f) _____
 - (g) _____
 - 10. Preparation for Medical Records Yes./No. _____
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11. Source of Drinking Water and Utility Water (Artesian Well | City Water Supply, etc.) _____
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12. Enough source of water Yes./No. (Average available water gallon per day) _____
-
13. Sewage System (Flushed Toilet, Drain Toilet) _____
-
14. 24 Hours Electricity Availability Yes./No. (Arrangement) _____
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 | Yes. | No. |
|---|--------------------------|--------------------------|
| (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"/> |
| 17. Patient Referral System Arrangement | <input type="checkbox"/> | <input type="checkbox"/> |
| (If Yes, attach the Referral Form) | | |
| 18. Availability of other Diagnostic Activities | <input type="checkbox"/> | <input type="checkbox"/> |
| (If Yes, apply separately) | | |
| 19. Storage system of Medicines and Medical Appliances (Describe with Photos) _____ | | |
| 20. Challan No. and Date for Payment of License Fee _____ | | |
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21. Recommendation of City Development Committee Yes./No. _____

(If Yes, attach herewith)

22. Receive Prior Permission Yes./No. _____

23. Clinic 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 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 _____

PaGaKa Form (B)

Signature of Applicant: _____

Name: _____

Contact Telephone: _____
