PaGaKa Form (C)

Private General Hospital Business

1. Applicant's Name _____
2. Citizen's Scrutinizing Card No. _____
3. Name of the Hospital _____
4. No. of Beds at present _____
5. Address of the Hospital _____
6. The number and distance of the nearest buildings around the Hospital _____

_____

_____

7. Land ownership document of the Hospital _____
8. Land Area of the Hospital (Length x Width) (describe in Feet/Acre)_____

_____

9. Area of the Hospital (Length x Width x Height) (describe in Feet) _____

_____

10. Arrangements of Ups and Downs (Type of Stairs) _____
11. Formation of Hospital's structure, rooms and areas (Attach with separate sheet) (Length x Width x Height) (describe in Feet)
    - in–patient Unit _____
    - Operation Theatre _____
    - Delivery Unit _____
    - Laboratory _____
    - Radiology Unit _____

– Intensive Care Unit _____

– Facilities for ICU Yes./No._____

(If Yes, provide name of equipment, quantity, whether useable or not with separate sheet.)

12. Photos of present formation of Hospital (East, Side and Inside) _____

13. Preparation for Medical Records Yes./No. _____

14. Source of Drinking Water and Utility Water (Artesian Well ı City Water Supply, etc.)

_____

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

_____

16. 24 Hours Electricity Availability Yes./No. (Arrangement)_____

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

_____

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

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19. Arrangement for the Patients

(a) Reception Area _____

(b) Waiting Area _____

(c) Examination room _____

(d) Injection/Pharmacy room _____

(e) Inpatient Units (distance between patient's beds)(Describe in Feet) _____

_____

(f) Arrangement for the dead body when the patient dead _____

20. Patient Referral System Arrangement (Ambulance Yes./No.) _____

(If Yes, attach the Referral Form)

21. 24 hours Duty Assignment (Yes./No.) _____

(If Yes, attach the Duty Roaster for Doctors and staffs)

22. Availability of other Diagnostic Activities

(If Yes, apply separately)

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

24. Pharmacy Shop available at Hospital Yes./No._____

25. Arrangements for Emergency Medicines _____

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

27. Recommendation of City Development Committee Yes./No. _____

(If Yes, attach herewith)

28. Receive Prior Permission Yes./No. _____

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

Month/Year of Opening _____

Approved Organization/ Evidence _____

Expiry Date _____

30. Fire Safety System Yes./No. _____

(If Yes, submit the prevention arrangement)

31. Responsible Personnel at the Hospital _____

(a) Name of Responsible Person _____

(b) Name of Chief/Head Physician _____

(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.)

32. Please describe any additional information _____

_____

_____

_____

Signature of Applicant: _____

Name:_____

Contact Telephone:_____