PaGaKa Form (E)

Private Maternity Clinic Business

1. Applicant's Name ____

2. Citizen's Scrutinizing Card No. ____________________________________

3. Name of the Maternity Clinic and Address ______________________________

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4. Land Area of the Maternity Clinic (Length x Width) (describe in Feet/Acre)_________

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5. Area of the Maternity Clinic (Length x Width x Height) (describe in Feet)___________

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6. Preparation for Medical Records Yes./No. ___________________________________

7. Source of Drinking Water and Utility Water (Artesian Well ၊ City Water Supply, etc.)

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8. Enough source of water Yes./No. (Average available water gallon per day) ________

____

9. 24 Hours Electricity Availability Yes./No. (Arrangement)_________________________

10. Sewage System (Flushed Toilet, Drain Toilet) _______________________________

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

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12. Arrangement for the Patients

    (a) Reception Area ____

    (b) Waiting Area ____

    (c) Examination room ____

    (d) Privacy for Patients ____

    (e) Specific place for injection/medication ________________________________

    (f) Complete facility for Delivery Room __________________________________

    (g) Availability of Sterilization System ____________________________________

13. Patient Referral System Arrangement

    (If Yes, attach the Referral Form)

14. Arrangement for Emergency Operation (Describe separately)

15. Availability of other Diagnostic Activities

    (If Yes, apply separately)

16. Storage system of Medicines and Medical Appliances (Describe with Photos)_______

17. Pharmacy Shop available at the Maternity Clinic Yes./No. ______________________

    (If Yes, is there a License issued by the Township Food and Drugs Administration)

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

19. Challan No. and Date for Payment of License Fee __________________________

20. Recommendation of City Development Committee for the Building Yes./No.________

    (If Yes, attach herewith)

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21. Receive Prior Permission Yes./No. ____________________________________

22. Previously Operated Yes./No. (if Yes.)____________________________________

Month/Year of Opening ____

Approved Organization/ Evidence ____________________________________

Expiry Date ____

23. Fire Safety System Yes./No. ____

(If Yes, submit the prevention arrangement)

24. Responsible Personnel at the Clinic ______________________________________

(a) Name of Maternity Clinic Responsible Person ___________________________

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(b)	Name of Chief/Head Physician (If any)	( )	No.
(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.)

25. Please describe any additional information ________________________________

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Signature of Applicant: ___________________________

Name:___________________________

Contact Telephone:___________________________