

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 | 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)

19. Arrangement for the Patients

(a) Reception Area _____

(b) Waiting Area _____

(c) Examination room _____

PaGaKa Form (C)

- (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 _____
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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: _____

