

Private Nursing Home Business

1. Applicant's Name \_\_\_\_\_
2. Citizen's Scrutinizing Card No. \_\_\_\_\_
3. Name of the Nursing Home and Address \_\_\_\_\_
4. Land Area of the Nursing Home (Length x Width) (describe in Feet/Acre) \_\_\_\_\_  
\_\_\_\_\_
5. Room Structure and area of the Nursing Home (Length x Width x Height) (describe in Feet) \_\_\_\_\_
6. Number of Bed of the Nursing Home \_\_\_\_\_
7. Preparation for Medical Records Yes./No. \_\_\_\_\_
8. Source of Drinking Water and Utility Water (Artesian Well | City Water Supply, etc.)  
\_\_\_\_\_
9. Enough source of water Yes./No. (Average available water gallon per day) \_\_\_\_\_  
\_\_\_\_\_
10. 24 Hours Electricity Availability Yes./No. (Arrangement) \_\_\_\_\_
11. Sewage System (Flushed Toilet, Drain Toilet) \_\_\_\_\_  
\_\_\_\_\_
12. Garbage management system Yes./No. (e.g – Burning Machine, City Development Arrangement and other arrangements)
13. Arrangement for the Patients (Yes./No.)
  - (a) Reception Area \_\_\_\_\_
  - (b) Waiting Area \_\_\_\_\_

PaGaKa Form (H)

(c) Examination room \_\_\_\_\_

(d) Privacy for Patient (Yes./No.) \_\_\_\_\_

(e) Injection/Pharmacy room (Yes./No.) \_\_\_\_\_

(f) Arrangement of providing food (Yes./No.) \_\_\_\_\_

14. Patient Referral System Arrangement (Yes./No.) (Ambulance)

(If Yes, attach the Referral Form)

15. Storage system of Medicines and Medical Appliances \_\_\_\_\_

16. Arrangement for Emergency Medication (Yes./No.) \_\_\_\_\_

17. Sterilization System (Yes./No.) \_\_\_\_\_

18. Challan No. and Date for Payment of License Fee \_\_\_\_\_

19. Recommendation by the City Development Committee for the Building Yes./No.

\_\_\_\_\_

(If Yes, attach herewith)

20. Receive Prior Permission Yes./No. \_\_\_\_\_

21. Previously Operated for Nursing Home Yes./No. (if Yes.) \_\_\_\_\_

Month/Year of Opening \_\_\_\_\_

Approved Organization/ Evidence \_\_\_\_\_

Expiry Date \_\_\_\_\_

22. Fire Safety System Yes./No. \_\_\_\_\_

(If Yes, submit the prevention arrangement)

23. Responsible Personnel at the Nursing Home \_\_\_\_\_

**PaGaKa Form (H)**

(a) Name of the Responsible Person of the Business \_\_\_\_\_

\_\_\_\_\_

(b) Specialists ( ) No.

(c) Medical Officers ( ) No.

(d) Nurses ( ) No.

(e) Nurse Aid ( ) No.

(To fill the personal information at the CV Form for each and every person.)

24. Please describe any additional information \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

Name: \_\_\_\_\_

Contact Telephone: \_\_\_\_\_