

Private General Health Care Service

1. Applicant's Name _____
2. Citizen's Scrutinizing Card No. _____
3. Name of the Business and Address _____
4. Land Area of the Clinic (Length x Width x Area) (describe in Feet/Acre) _____
5. Area of the Business Building (Length x Width x Height) (describe in Feet) _____
6. Formation of Business rooms' structure and areas (Attach with separate sheet)
7. List of businesses to be carried out and the required equipment for each and every business (to be attached) _____
8. Arrangement for Medical Records Yes./No. _____
9. Source of Drinking Water and Utility Water (Artesian Well | City Water Supply, etc.)

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

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

12. 24 Hours Electricity Availability Yes./No. (Arrangement) _____
13. Garbage management system Yes./No. (e.g - Burning Machine, City Development Arrangement and other arrangements)

PaGaKa Form (K)

- | | Yes. | No. |
|---|--------------------------|--------------------------|
| 14. Arrangement for the Patients | | |
| (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) Privacy for the Patients | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Patient Referral System Arrangement | <input type="checkbox"/> | <input type="checkbox"/> |
| (If Yes, attach the Referral Form) | | |
| 16. Availability of other Diagnostic Activities | <input type="checkbox"/> | <input type="checkbox"/> |
| (If Yes, apply separately) | | |
| 17. Storage system of Medicines, Medical Appliances and machine, equipment for business use _____ | | |
| 18. Arrangements of Emergency Medicines Yes./No. _____ | | |
| 19. Sterilization System Yes./No. _____ | | |
| 20. Challan No. and Date for Payment of License Fee _____ | | |
| 21. Recommendation for the building by the City Development Committee for the Yes./No. _____ | | |
| (If Yes, attach herewith) | | |
| 22. Receive Prior Permission Yes./No. _____ | | |
| 23. 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 fire prevention arrangement)

25. Responsible Personnel at the Business _____

(a) Name of Responsible Person of the Business _____

(b) Specialists () No.

(c) Medical Officers () No.

(d) Nurses () No.

(e) Nurse Aid () No.

(f) Other Staff () No.

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

26. Please describe any additional information _____

Signature of Applicant: _____

Name: _____

Contact Telephone: _____