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                                                                                 متخصص                      تاریخ   زمان فعالیت:            صبح         عصر               شب                                        فوق تخصص                   پیوست   آدرس مطب :   کد پستی :                      تلفن :                           منطقه :               تعداد تابلو:  تعداد تابلوهای استاندارد :                                      تعداد تابلوهای غیر استاندارد :                                                  عناوین تابلو: | | | | | |  | بله |  | خیر |  | | پروانه مطب معتبر دارد ؟ |  |  |  |  | | پروانه مناسب در معرض دید قرار دارد ؟ |  |  |  |  | | دفتر ثبت پذیرش بیمار دارد ؟ |  |  |  |  | | میزان دریافت ویزیت طبق تعرفه است ؟ |  |  |  |  | | معاینه به صورت انفرادی انجام می شود ؟ |  |  |  |  | | پرونده برای بیماران تشکیل می شود ؟ |  |  |  |  | | نظافت و بهداشت فردی و عمومی رعایت می شود ؟ |  |  |  |  | | روپوش سفید و تمیز استفاده می شود ؟ |  |  |  |  | | تخت معاینه مناسب و پوشیده با کاغذ گراف با ملحفه سفید و تمیز است ؟ |  |  |  |  | | تخت ژنیکلوژی با کاغذ گراف پوشانده شده است ؟ |  |  |  |  | | اتاق معاینه دستشویی دارد ؟ |  |  |  |  | | نور اتاق معاینه مناسب است ؟ |  |  |  |  | | نسخه پزشک خوانا است ؟ |  |  |  |  | | مطب پزشک فاقد داروهای اضافی می باشد ؟ |  |  |  |  | | سیستم تهویه مطبوع مناسب وجود دارد ؟ |  |  |  |  | | نمای ظاهری و رنگ آمیزی دیوارها مناسب است ؟ |  |  |  |  | | وضعیت راهروها و پله ها مناسب است ؟ |  |  |  |  | | نظریه کارشناسان : | | | | |      |  |  |  |  |  | | --- | --- | --- | --- | --- | | نام و نام خانوادگی پزشک :                                   پزشک عمومی               شماره   نام مسئول تزریقات : متخصص                      تاریخ   زمان حضور مسئول تزریقات        صبح         عصر   فوق تخصص                   پیوست   مدرک تحصیلی مسئول تزریقات : | | | | | |  | بله |  | خیر |  | | مجوز کار دارد ؟ |  |  |  |  | | مجوز نصب دارد ؟ |  |  |  |  | | آیا فعالیت واحد تزریقات زیر نظر پزشک انجام می شود ؟ |  |  |  |  | | وضعیت عمومی اتاق تزریقات مناسب با اهداف بهداشتی ، درمانی و عاری از وسیله غیر لازم می باشد ؟ |  |  |  |  | | وسائل احیاء ( آمبوبگ ، ماسک ، ایروی ) وجود دارد ؟ |  |  |  |  | | کپسول اکسیژن با مانومتر سالم وجود دارد ؟ |  |  |  |  | | داروهای اورژانس قابل دسترس به تعداد کافی و با تاریخ مصرف معتبر وجود دارد ؟ |  |  |  |  | | فور یا اتو کلاو دارد ؟ |  |  |  |  | | پاراوان سالم و تمیز موجود می باشد ؟ |  |  |  |  | | پایه سرم برای مواقع اضطراری وجود دارد ؟ |  |  |  |  | | تخت تزریقات ، ملحفه سفید و تمیز دارد ؟ |  |  |  |  | | سرسوزنها مصرف شده به طریق صحیح جمع آوری می شود ؟ |  |  |  |  | | دفتر ثبت تزریقات دارد ؟ |  |  |  |  | | اتاق تزریقات دستشویی دارد ؟ |  |  |  |  | | امکانات لازم برای سرم درمانی وجود دارد ؟ |  |  |  |  | | تخت و داروهای اضافی وجود دارد ؟ |  |  |  |  | | آیا تعرفه تزریقات رعایت می شود ؟ |  |  |  |  | | نظریه کارشناسان : | | | | | | | | : |  | | | معاونت درمان  مدیریت نظارت و ارزشیابی   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | وزارت بهداشت ، درمان و آموزش پزشکی معاونت درمان  دفتر نظارت و اعتبار بخشی امور درمان  **فرم درخواست موافقت اصولی**   |  |  |  | | --- | --- | --- | | فرم شماره 1 - الف | | | | مشخصات موسسه : | | | | نام پیشنهادی مؤسسه ( انتخاب نام در این مرحله کاملاً الزامی است ) : | | | | **نوع موسسه :** ( تنها یک مورد بایستی انتخاب گردد . )   بیمارستان عمومی      درمانگاه عمومی      مرکز جراحی محدود       مرکز درمان ناباروری         مرکز درمان سوء مصرف مواد  **درمانگــاه تخصصی :**   (  داخلی ،      غیرتهاجمی قلب و عروق   ،     آلرژی   ،      چند تخصصی مغز و اعصاب و روان   ،  چند تخصصی درد ،  دیابت ،    پوست )    درمانگاه دندانپزشکی    مرکز درمان با اکسیژن هایپربارد    موسسه پزشکی هسته ای    آمبولانس خصوصی  ارتوپدی فنی  موسسه ساخت و فروش عینک طبی        مرکز تخصصی طب کار     فیزیوتراپی       مرکز تصویربرداری       موسسه رادیولوژی و سونوگرافی   موسسه رادیولوژی دهان و فک و صورت           موسسه رادیوتراپی   **مرکز جامع توانبخشی :**   ( تعیین گرایش مرکز از میان گزینه های زیر الزامی است )   گرایش اختلالات بینائی     گرایش اختلالا جسمی حرکتی      گرایش سالمندان       گرایش فلج مغزی        گرایش اختلالات اعصاب و روان   گرایش اختلالات ذهنی کودکان و نوجوانان      گرایش اختلالات رفتاری روانی کودکان و نوجوانان       گرایش اختلالات شنوائی ، گفتار و زبان    مرکز ارائه خدمات و مراقبت های بالینی در منزل       مرکز مشاوره و ارائه خدمات مامائی      مرکز مشاوره و ارائه خدمات پرستاری   شرکت تعاونی خدمات بهداشتی درمانی | | | | دانشگاه : | شهر : | منطقه :  ( برای شهرهایی که دارای منطقه شهرداری می باشند الزامی است .) | | **نوع مالکیت موسسه :**    حقیقی       حقوقی خصوصی           تعاونی خدمات بهداشتی درمانی          خیریه        عمومی  تذکر 1 : منظور از مالکیت عمومی ، وابستگی موسسه به یکی از سه قوای سه گانه نیروهای مسلح یا ذکر سازمانهای دولتی و یا نهادهای عمومی غیردولتی   ( مانند شهرداری ها ، هلال احمر ، سازمان تأمین اجتماعی و ... ) است .  تذکر 2 : کسانی که متقاضی تأسیس شرکت تعاونی خدمات بهداشتی درمانی می باشند و تاکنون شرکتی تأسیس ننموده اند .می بایست گزینه حقیقی را انتخاب نمایند . در صورت انتخاب گزینه عمومی ، خیریه ، حقوقی ، تعاونی نام سازمان ، ارگان یا شرکت مربوطه در ردیف زیر نوشته شود . | | | | **نام رسمی سازمان ، شرکت یا مؤسسه ی خیریه :**  با توجه به اینکه نام سازمان عیناً در پروانهبهره برداری قید می شود ، لطفاً نام سازمان ، ارگان یا شرکت را بطور کامل مانند نمونه های زیر بنویسید .  مثال : شرکت تعاونی و خدمات بهداشتی درمانی پیام سلامت یا بنیاد امور خیریه حضرت علی بن موسی الرضا (ع) یا سازمان هلال احمر | | | | **نوبت کاری موسسه :**             صبح                    عصر                صبح و عصر                شبانه روزی | | | | تعداد کل تخت ( مخصوص بیمارستان ) : | | |     **نام و نام خانوادگی نماینده متقاضیان تأسیس :**  **پست الکترونیکی :**  **تلفن تماس ( ترجیحاً همراه ) :**  در صورتیکه متقاضی تأسیس یک نفر باشد نیاز به اطلاعات فوق نمی باشد .            وزارت بهداشت ، درمان و آموزش پزشکی  معاونت درمان  دفتر نظارت و اعتبار بخشی امور درمان  **فرم درخواست موافقت اصولی**  **فرم شمــاره 1 – ب**    با توجه به اینکه مشخصات کامل متقاضیان تأسیس باید در فرم ورود اطلاعات متقاضیان تأسیس ثبت شود در این قسمت تنها نام و نام خانوادگی و کدملی متقاضیان تأسیس نوشته شود .    1- حقیقی :  تعداد متقاضیان تأسیس : .............. نفر      **نام متقاضیان تأسیس :**       |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | ردیف | نام و نام خانوادگی | کدملی |  | ردیف | نام و نام خانوادگی | کدملی | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  |          وزارت بهداشت ، درمان و آموزش پزشکی معاونت درمان                  دفتر نظارت و اعتبار بخشی امور درمان  **فرم درخواست موافقت اصولی**  **فرم شمــاره 2**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | مشخصات متقاضی تأسیس | | | | | | **مشخصات فردی** | نام : | نام خانوادگی: | کدملی : | نام پدر : | | شماره شناسنامه : | محل صدور : | تاریخ :           /        / | محل تولد : | | **مشخصات تماس** | نشانی محل سکونت :  شهر :                        خیابان اصلی :                              خیابان فرعی :                                پلاک :                   کدپستی :  پیش شماره :                                 تلفن :                                                                          تلفن همراه :  پست الکترونیک :                                                                                                            وب سایت : | | | | | **مدرک تحصیلی ( آخرین مقطع )** | **این قسمت بر اساس پروانه دائم / یا دانشنامه / یا پایان طرح نیروی انسانی / یا آخرین مدرک تحصیلی تکمیل گردد .** | | | | | **مقطع :**  کاردان       کارشناس     کارشناس ارشد      دکترای حرفه ای       PhD       متخصص            فوق تخصص  **رشته / تخصص :**  **نوع دانشگاه :**     دانشگاه علوم پزشکی        دانشگاه آزاد اسلامی       سایر دانشگاههای کشور         دانشگاه های خارج از کشور  **دانشگاه محل تحصیل :**                         نام دانشگاه :                                زمان فارغ التحصیلی :                  شماره نظام نظام پزشکی :  تذکـر : شماره نظامهایی که توام با حروف و اعداد میباشند به صورت نمونه نوشته شوند : م – 1996 | | | | | **وضعیت اشتغال قطعی** |  عدم وابستگی استخدامی به دولت           عصو هیئت علمی رسمی با پیمانی تمام وقت وزارت بهداشت یا دانشگاه علوم پزشکی   عضو هیئت علمی نیمه وقت                 کارمند رسمی یا پیمانی غیر هیئت علمی وزارت بهداشت یا دانشگاه علوم پزشکی   کارمند رسمی یا پیمانی سایر وزارتخانه ها یا سازمانها         کارمند قراردادی وزارت بهداشت یا سایر سازمانها          کارمند بازنشسته | | | |   **در صورت داشتن پروانه مطب پر کردن جدول زیر الزامی است .**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | **مشخصات پروانه مطب** | | شهر :                                      تاریخ صدور :                                               تاریخ اعتبار : | |  | | **سوابق کاری ( بعد از فارغ التحصیلی از دانشگاه )** | | | | | | | ردیف | | ارگان یا محل انجام کار | | طول مدت خدمت ( به ماه ذکر شود ) | | |  | |  | |  | | |  | |  | |  | | |  | |  | |  | | |  |  |  |  |  |  |   **مجموع مدت سوابق کار : ............ ماه چنانچه در حال حاضر در موسسه درمانی دیگری ، موسس / مسئول فنی می باشید جدول زیر را تکمیل کنید :**   |  |  |  |  | | --- | --- | --- | --- | | نوع موسسه : | نام موسسه : | نوع هویت موسس :  حقیقی  حقوقی خصوصی  تعاونی خدمات بهداشتی درمانی  خیریه | | |  |  |  |  | | **نام دانشگاه ( منظور دانشگاهی است که موسسه فوق تحت پوشش آن قرار دارد )** | | |  |                     وزارت بهداشت ، درمان و آموزش پزشکی                                      معاونت درمان                  دفتر نظارت و اعتبار بخشی امور درمان  **فرم درخواست موافقت اصولی**  **مدارک متقــاضی تـأسیس**     |  |  |  | | --- | --- | --- | |  اصل فرم های تقاضای موافقت اصولی  ( فرم شماره 1 « الف و ب » و فرم شماره 2 ) | پزشک و دندانپزشک  داروساز  دکترای علوم آزمایشگاهی  کایروپراکتیک ، ماما |  اصل و تصویر پروانه دائم   اصل گواهی عدم سوء پیشینه انتظامی از سازمان نظام پزشکی | |  اصل فرم تقبل وظایف موسس | |  اصل و تصویر کارت ملی | پیرا پزشک |  اصل و تصویر ( دانشنامه ) / یا ( تسویه حساب صندوق رفاه + پایان طرح با معافیت از طرح )  سابقه فعالیت لازم در خصوص موسسین فیزیوتراپی در 5 شهر بزرگ مطابق با آئین نامه مربوطه | |  اصل گواهی عدم اعتیاد | سایرین |  اصل و تصویر آخرین مدرک تحصیلی | |  اصل گواهی عدم سوء پیشینه کیفری از اداره تشخیص هویت | |  کارت پایان خدمت یا کارت معافیت از خدمت   ( ویژه آقایان ) | منظور از مدارک عمومی مدارکی است که کلیه متقاضیان تأسیس  ( بدون در نظر گرفتن مدرک تحصیلی و نوع موسسه ) باید ارائه نمایند .  مدارک اختصاصی بر اساس مدرک تحصیلی متقاضیان تأسیس باید ارائه شود و مربوط به کلیه متقاضیان تأسیس نمی باشد . | | |  اصل و تصویر ( آخرین حکم کارگزینی ) /  ( یا تأییدیه اشتغال از بالاترین مقام مسوول اداری برای مستخدمین کشوری و لشکری که دارای حکم کارگزینی نیستند )  ( ویژه مستخدمین کشوری و لشکری ) | | قرارداد تأسیس امضاء شده توسط متقاضی یا متقاضیان |     چک لیست مدارک لازم جهت اخذ موافقت اصولی مربوط به متقاضیان غیر حقیقی ( علاوه بر مدارک فردی متقاضیان تأسیس )   |  |  |  |  | | --- | --- | --- | --- | | شرکت تعاونی خدمات بهداشتی درمانی | خیریه | حقوق خصوصی | عمومی | |  اساسنامه شرکت |  اساسنامه خیریه |  اساسنامه شرکت با قید اجازه فعالیت بهداشتی درمانی در آن |  نامه درخواست از بالاترین مقام بهداشتی درمانی مربوطه | |  گواهی ثبت شرکتها |  لیست هیئت امنا |  گواهی ثبت شرکتها |  تأییدیه وزارت بهداشت و مصوبه هیئت محترم وزیران | |  آگهی ثبت شرکت در روزنامه رسمی |  نامه دفتر خدمات خیریه بهداشتی درمانی |  آگهی ثبت شرکت در روزنامه رسمی |  | |  موافقت اصولی تعاونی | **شماره ثبت :** | **شماره ثبت :** |  | | **شماره ثبت :** |  | | |                             وزارت بهداشت ، درمان و آموزش پزشکی                                      معاونت درمان                  دفتر نظارت و اعتبار بخشی امور درمان  **فرم درخواست موافقت اصولی**    **تأیید صحت مشخصات و تعهدنامه متقاضی تأسیس :**  اینجانب :                                                                                               تصدیق می نمایم :  1- با دقت و صحت این فرم را تکمیل نموده و مندرجات آنرا قبول دارم .  2- آئین نامه موسسه درخواستی را مطالعه و با توجه به مفاد آن ، این درخواست را ارائه نموده و متعهد به اجرای آن می باشم .  3- مدارک را طبق آئین نامه و ضوابط اعلام شده ارائه نموده ام .  4- با در نظر گرفتن این درخواست ، به صورت حقیقی موسس موسسه دیگری نبوده و موافقت اصولی و یا پروانه بهره برداری دریافت ننموده ام و در صورتی که خلاف این امر اثبات شود دانشگاه مجاز خواهد بود موافقت اصولی صادر شده را ابطال نموده و حق گونه اعتراضی نخواهم داشت .  5- به صورت حقوقی ( خیریه ، شرکت تعاونی یا سایر شرکت های ثبت شده ) اصولی و یا پروانه بهره برداری موسسه دیگری را دریافت نموده ام .   بلی              خیر  در صورت پاسخ مثبت لطفاً جدول زیر تکمیل گردد :   |  |  |  |  | | --- | --- | --- | --- | | نوع موسسه | نام موسسه | دانشگاه \* | نحوه مشارکت :  خیریه – سایر شرکتها  شرکت تعاونی خدمات بهداشتی ، درمانی | |  |  |  |  |     \* منظور دانشگاهی است که موسسه مذکور تحت پوشش آن قرار دارد.  **نام و نام خانوادگی – امضا و درج مهرنظام پزشکی :**     |  | | --- | | **این قسمت توسط معاونت درمان دانشگاه تکمیل می شود .** | | صحت مندرجات فرم و تعداد .......... برگ مدارک پیوست مورد تأیید اینجانب .......................................( کارشناس صدور پروانه ها ) است .      **تاریخ :                                                                                       امضاء :** | |  صدور موافقت اصولی بلامانع است .                                                                                                   **امضاء معاون درمان** |     در صورت وجود بیش از یک نفر موسس ، این فرم باید برای هر فرد جداگانه تکمیل و امضاء شود . | | | تاریخ آخرین به روزرسانی : | 1394/07/07 | | | |  |  | | --- | --- | | **فرم بازدید از مطب دندانپزشکان**     1    http://www.gums.ac.ir/Upload/Modules/Contents/asset96/Picture.jpg           2  http://www.gums.ac.ir/Upload/Modules/Contents/asset96/Picture%20001.jpg | | | تاریخ آخرین به روزرسانی : | 1394/06/11 | | | |  | | [[افزودن محتوا]](http://www.gums.ac.ir/anzali/module/contents/ContentsManager/page-14875/index.aspx) | |  | | | |  |  |  | | --- | --- | --- | |  |  |  | | | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  | |  |  | | --- | --- | |  | آمار مراجعات | |  |  | |  | | | |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | امروز: | 1 | دیروز: | 1 | کل مراجعات: | 51 | | | |  | | | |  |  |  | | --- | --- | --- | | 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|  | |  | | --- | |  | | * [صفحه اصلی](http://www.gums.ac.ir/anzali/tab-6426/%d8%b5%d9%81%d8%ad%d9%87-%d8%a7%d8%b5%d9%84%db%8c.aspx) * [خروج](http://www.gums.ac.ir/anzali/tab-6539/%d8%ae%d8%b1%d9%88%d8%ac-%d8%a7%d8%b2-%d9%be%d9%88%d8%b1%d8%aa%d8%a7%d9%84-%d8%b4%d8%a8%da%a9%d9%87-%d8%a8%d9%87%d8%af%d8%a7%d8%b4%d8%aa-%d9%88-%d8%af%d8%b1%d9%85%d8%a7%d9%86--%d8%a7%d9%86%d8%b2%d9%84%db%8c.aspx) * [نقشه سایت](http://www.gums.ac.ir/anzali/tab-6540/%d9%86%d9%82%d8%b4%d9%87-%d8%b3%d8%a7%db%8c%d8%aa-%d8%b4%d8%a8%da%a9%d9%87-%d8%a8%d9%87%d8%af%d8%a7%d8%b4%d8%aa-%d9%88-%d8%af%d8%b1%d9%85%d8%a7%d9%86-%d8%a7%d9%86%d8%b2%d9%84%db%8c.aspx) * [ورود کاربران](http://www.gums.ac.ir/anzali/tab-6541/%d9%88%d8%b1%d9%88%d8%af-%da%a9%d8%a7%d8%b1%d8%a8%d8%b1%d8%a7%d9%86-%d8%b4%d8%a8%da%a9%d9%87-%d8%a8%d9%87%d8%af%d8%a7%d8%b4%d8%aa-%d9%88-%d8%af%d8%b1%d9%85%d8%a7%d9%86-%d8%a7%d9%86%d8%b2%d9%84%db%8c.aspx) | |  |

کلیه حقوق متعلق به دانشگاه علوم پزشکی و خدمات بهداشتی درمانی استان گیلان می باشد.  
تاریخ آخرین به روز رسانی: 1394/07/30   
[پورتال پالیز-Paliz Portal 6.5.5](http://www.palizct.com/Default.aspx)