PATIENT INFORMATION:

Herks Viols

Phone (H): (402) 456 5432
DOB: 04/27/1994
Gender: Male **Age:** 31
Patient ID: 328791

STATUS: **Final**

Source: TestingLab Facility
Time Reported: 12/16/2025 01:00 PM
Received: 12/16/2025 07:01 AM
Accession Number: 38738
Lab Ref #: 27627

ORDERING PHYSICIAN:

UrgentIQ Testing Test SSO

285 Central Park West
New York, NY, 10024

Test	In Range	Out Of Range	Reference Range	Lab
BRUICE BASIC FEMALE 1438				
1234-4 BRUICE BASIC FEMALE		**19.2** **HH**	5.0-9.0 m/l	

Range Flags Legend: HH - Above upper panic limit;

HEALTH GORILLA™

HEALTHCARE

Patient: Herks Viols (04/27/1994 - 31y), Male
Address: Mountainview Dr Boardman, OR 97818
Phone: (402) 456-5432
Seen On: 12/16/2025

Seen At: DoseSpotClinic
Address: 123 N Main St str 2
Brooklyn, MI 49230
Phone: (956) 825-0925
Fax: (332) 241-0212
Provider:

Chief Complaint

Asthma
Source: Self

Vitals

Vitals:
Air Source: Room Air

Set 1:

History of Present Illness

No history of present illness data entered

PAST MEDICAL HISTORY

Allergies

No allergies entered

Medication

No medications entered
36RK
406 SMART DRIVe
CAYTON, AL 36016
Phone: (412) 370-4500
Fax: (412) 980-4567

Immunization

No immunizations entered

Surgical History

No surgical history entered

Medical Condition

No past medical history entered

Preventative Med Notes

No preventativeMedNotes entered

HEALTHCARE

Patient: Herks Viols (04/27/1994 - 31y), Male
Address: Mountainview Dr Boardman, OR 97818
Phone: (402) 456-5432
Seen On: 12/16/2025

Seen At: DoseSpotClinic
Address: 123 N Main St str 2
Brooklyn, MI 49230
Phone: (956) 825-0925
Fax: (332) 241-0212
Provider:

Social History

No social history entered

Family History

No family history entered

Review of Systems

No review of systems data entered

Exam

No examination data entered

Orders & Procedures

No procedures entered
Lab Requests:
BRUICE BASIC FEMALE

Assessment/Plan

No assessment plan entered

External Orders:
Order File: Herks Viols Order to TestingLab Facility 12/16/2025.pdf
Result: BRUICE BASIC FEMALE

Prescription

Signature

Addendums

HEALTHCARE

Patient: Herks Viols (04/27/1994 - 31y), Male
Address: Mountainview Dr Boardman, OR 97818
Phone: (402) 456-5432
Seen On: 12/16/2025

Seen At: DoseSpotClinic
Address: 123 N Main St str 2
Brooklyn, MI 49230
Phone: (956) 825-0925
Fax: (332) 241-0212
Provider:

Chief Complaint

Asthma
Source: Self

Vitals

Vitals:
Air Source: Room Air

Set 1:

History of Present Illness

No history of present illness data entered

PAST MEDICAL HISTORY

Allergies

No allergies entered

Medication

No medications entered
36RK
406 SMART DRIVe
CAYTON, AL 36016
Phone: (412) 370-4500
Fax: (412) 980-4567

Immunization

No immunizations entered

Surgical History

No surgical history entered

Medical Condition

No past medical history entered

Preventative Med Notes

No preventativeMedNotes entered

HEALTHCARE

Patient: Herks Viols (04/27/1994 - 31y), Male
Address: Mountainview Dr Boardman, OR 97818
Phone: (402) 456-5432
Seen On: 12/16/2025

Seen At: DoseSpotClinic
Address: 123 N Main St str 2
Brooklyn, MI 49230
Phone: (956) 825-0925
Fax: (332) 241-0212
Provider:

Social History

No social history entered

Family History

No family history entered

Review of Systems

No review of systems data entered

Exam

No examination data entered

Orders & Procedures

No procedures entered
Lab Requests:
BRUICE BASIC FEMALE

Assessment/Plan

No assessment plan entered

External Orders:
Order File: Herks Viols Order to TestingLab Facility 12/16/2025.pdf
Result: BRUICE BASIC FEMALE

Prescription

Signature

Addendums

HEALTH GORILLA

EREQ

27627

TestingLab Facility

Patient Service Center Hold

UrgentIQ
285 Central Park West
New York, NY, 10024

Bill To: Patient

Patient Information
Herks Viols Mountainview Dr Boardman, OR, 97818 H: (402) 456-5432

Lab Reference ID: 27627	**Pat ID #:** 328791 DOB: 04/27/1994 Sex: Male
NPI: 1164469938 Ref Physician Provider: UrgentIQ Testing Test SSO	**Guarantor:** Viols, Herks DOB: 04/27/1994 Mountainview Dr Phone (H): (402) 456 5432 Boardman, OR, 97818

Profiles / Tests

1438 BRUICE BASIC FEMALE (Routine)

Patient's Signature: _____ (acknowledgment of tests being obtained)

ELECTRONICALLY SIGNED BY UrgentIQ Testing Test SSO 12/16/2025 01:59 AM EST

HEALTHCARE

Patient: Herks Viols (04/27/1994 - 31y), Male
Address: Mountainview Dr Boardman, OR 97818
Phone: (402) 456-5432
Seen On: 12/16/2025

Seen At: DoseSpotClinic
Address: 123 N Main St str 2
Brooklyn, MI 49230
Phone: (956) 825-0925
Fax: (332) 241-0212
Provider:

Chief Complaint

Asthma
Source: Self

Vitals

Vitals:
Air Source: Room Air

Set 1:

History of Present Illness

No history of present illness data entered

PAST MEDICAL HISTORY

Allergies

No allergies entered

Medication

No medications entered
36RK
406 SMART DRIVe
CAYTON, AL 36016
Phone: (412) 370-4500
Fax: (412) 980-4567

Immunization

No immunizations entered

Surgical History

No surgical history entered

Medical Condition

No past medical history entered

Preventative Med Notes

No preventativeMedNotes entered

HEALTHCARE

Patient: Herks Viols (04/27/1994 - 31y), Male
Address: Mountainview Dr Boardman, OR 97818
Phone: (402) 456-5432
Seen On: 12/16/2025

Seen At: DoseSpotClinic
Address: 123 N Main St str 2
Brooklyn, MI 49230
Phone: (956) 825-0925
Fax: (332) 241-0212
Provider:

Social History

No social history entered

Family History

No family history entered

Review of Systems

No review of systems data entered

Exam

No examination data entered

Orders & Procedures

Status: In Progress
Procedure: 16 Universal Basic Knee Splint
Category: Procedure

Lab Requests:
BRUICE BASIC FEMALE

Assessment/Plan

No assessment plan entered

External Orders:
Order File: Herks Viols Order to TestingLab Facility 12/16/2025.pdf
Result: BRUICE BASIC FEMALE

Prescription

Signature

Addendums

Clinic Name	LOGO
Address :	
Phone No.:	
Email ID:	
GSTIN:	
State:	

Tax Invoice

Bill To:		**Patient Name**	
Name:		Age:	
Address:		Blood Group:	
Contact No.:		**Invoice No.:**	
GSTIN No.:		**Date:**	DD/MM/YYYY
State:			

#	Service name	HSN	QTY	Unit	Price/ Unit	Disc	GST	Amount
Total								

	Sub Total:	
	Discount:	
Amount in words:	SGST	
	CGST	
	Total	
	Received	
	Balance	
	Payment Mode:	
Company seal and Sign		

"Different levels of heart rate might reflect certain medical conditions," says Dr. Tilahun. "However, it doesn't always necessarily mean there's something going on. And that's why heart rate is important—because it can be a hint to at least consider exploring those possibilities."

Normal Resting Heart Rate Chart By Age

Normal heart rate varies, according to your age. Below is the normal heart rate by age, according to the National Institutes of Health.

AGE	NORMAL RESTING HEART RATE
Newborns ages 0 to 1 month	70 to 190 bpm
Infants 1 to 11 months old	80 to 160 bpm
Children 1 to 2 years old	80 to 130 bpm
Children 3 to 4 years old	80 to 120 bpm
Children 5 to 6 years old	75 to 115 bpm
Children 7 to 9 years old	70 to 110 bpm
Children 10 years and older and adults (including seniors)	60 to 100 bpm
Athletes in top condition	40 to 60 bpm

HEALTHCARE

Patient: Herks Viols (04/27/1994 - 31y), Male
Address: Mountainview Dr Boardman, OR 97818
Phone: (402) 456-5432
Seen On: 12/16/2025

Seen At: DoseSpotClinic
Address: 123 N Main St str 2
Brooklyn, MI 49230
Phone: (956) 825-0925
Fax: (332) 241-0212
Provider:

Chief Complaint

Asthma
Source: Self

Vitals

Vitals:
Air Source: Room Air

Set 1:

History of Present Illness

No history of present illness data entered

PAST MEDICAL HISTORY

Allergies

No allergies entered

Medication

No medications entered
36RK
406 SMART DRIVe
CAYTON, AL 36016
Phone: (412) 370-4500
Fax: (412) 980-4567

Immunization

No immunizations entered

Surgical History

No surgical history entered

Medical Condition

No past medical history entered

Preventative Med Notes

No preventativeMedNotes entered

HEALTHCARE

Patient: Herks Viols (04/27/1994 - 31y), Male
Address: Mountainview Dr Boardman, OR 97818
Phone: (402) 456-5432
Seen On: 12/16/2025

Seen At: DoseSpotClinic
Address: 123 N Main St str 2
Brooklyn, MI 49230
Phone: (956) 825-0925
Fax: (332) 241-0212
Provider:

Social History

No social history entered

Family History

No family history entered

Review of Systems

No review of systems data entered

Exam

No examination data entered

Orders & Procedures

Status: In Progress
Procedure: 16 Universal Basic Knee Splint
Category: Procedure

Lab Requests:
BRUICE BASIC FEMALE

Assessment/Plan

No assessment plan entered

External Orders:
Order File: Herks Viols Order to TestingLab Facility 12/16/2025.pdf
Result: BRUICE BASIC FEMALE

Prescription

Signature

Addendums

Order Form

12/06/2023

DoseSpotClinic
N Washington Ave
Green Brook, NJ 08812

NPI:

Phone: (860) 944-9421 Fax: (860) 995-9416

Stewart Slater Male 01/02/2000
(860) 955-9531

Scott Dr
Hillsborough, NJ 08844

Primary Insurance

Insurance Address

Subscriber Name

Insured Name

Address

Priority:

ICD10 Code

MR MUSCULOSKELETAL

- ☐ Shoulder
- ☐ Elbow ☐L ☐R
- ☐ Wrist ☐L ☐R
- ☐ Hand ☐L ☐R
- ☐ Hip ☐L ☐R
- ☐ Knee ☐L ☐R
- ☐ Lower Leg ☐L ☐R
- ☐ Ankle ☐L ☐R
- ☐ Foot ☐L ☐R
- ☐ MR Arthrography Specify joint:

MR BODY

- ☐ Abdomen ☐ Pelvis
- ☐ MRCP ☐ Liver
- ☐ Kidney

MR NEURO

- ☐ Brain
- ☐ IAC's/Orbits
- ☐ Pituitary
- ☐ Soft Tissue Neck
- ☐ Brachial Plexus ☐L ☐R
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
  - ☐ w/3D Myelogram
- ☐ Sacrum/Coccyx
- ☐ WEIGHT BEARING MRI

MR SPECIAL

- ☐ Breast
- ☐ Cardiac
- ☐ Enterography (MRE)
- ☐ Prostate
- ☐ TMJ
- ☐ Urogram
  (Abd/Pel w/wo with 3D recon)

MRA

- ☐ Brain ☐ Carotid
- ☐ Abdomen ☐ Kidney
- ☐ Runoff (Abd, Pel, Bilat legs)
- ☐ MRV Specify area of interest:

☐ MR OTHER Specify area of interest:

CT NEURO

- ☐ Brain ☐ Sinus
- ☐ Facial Bones
- ☐ IAC's/Temporal Bone
- ☐ Orbits ☐ Soft Tissue Neck
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine

CT MUSCULOSKELETAL ☐

Extremity (Specify area of interest)

☐ w/3D Recon.

☐ CT Arthography (Specifc Joint)

CT BODY

- ☐ Chest ☐ Abdomen ☐ Pelvis
- ☐ Urogram (Abd/Pel w/wo with 3D recon)
- ☐ Cardiac Calcium Score
- ☐ Low Dose Lung Screen

VASCULAR CT ANGIOGRAPHY

(All with IV contrast–no oral contrast)

- ☐ CTA Brain ☐ CTA Carotids
- ☐ CTA Chest (Pulmonary Embolus Protocol)
- ☐ CTA Aorta (Chest, Abd, Pel)
- ☐ CTA Coronary Arteries
- ☐ CTA Venous Structure
- ☐ CT OTHER (Specify area of interest)

_____

X-RAY/FLUOROSCOPY

- ☐ Chest ☐ Abdomen
- ☐ Pelvis ☐ Cervical Spine
- ☐ Thoracic Spine ☐ Flex
- ☐ Lumbar Spine ☐ Ext.
- ☐ Scoliosis/AP & LAT (T+L Spine)
- ☐ Pelvis Hip ☐RT &/or ☐LT
- ☐ Upper Extremity Indicate Site:
  _____ ☐RT ☐LT
- ☐ Lower Extremity Indicate Site:
  _____ ☐RT ☐LT
- ☐ Upper GI-W/Air per Rad*
- ☐ Ba Enema-W/Air per Rad*
- ☐ Esophagram*
- ☐ Small Bowl Study*
- ☐ Other

NUCLEAR MEDICINE Provide comparison films

- ☐ DaTscan
- ☐ Bone Scan Whole Body
- ☐ Bone Scan 3 Phase of:

☐ Bone Scan Limited of:

- ☐ Hepatobiliary Scan (HIDA)
  ☐ With EF ☐ W/O EF
- ☐ Thyroid Scan & Uptake*
- ☐ Liver/Spleen Scan
- ☐ Parathyroid Scan with SPECT
- ☐ Muga Resting
- ☐ Gastric Emptying Scan* Single Phase Only
- ☐ Renogram* ☐Lasix ☐No Lasix
- ☐ Renogram* With Captopril
- ☐ Lung Scan ☐Vent/LPerf ☐Quantilation
- ☐ Other _____

WOMEN'S IMAGING

- ☐ 3D Mammogram - Screening
- ☐ 3D Mammogram - Diagnostic
  w/ CAD and Breast US if questionable mammo ☐L ☐R ☐B
- ☐ Breast US - Screening ☐L ☐R ☐B
- ☐ Breast US - Diagnostic ☐L ☐R ☐B
- ☐ DEXAscan ☐L ☐R ☐B
- ☐ Stereotactic Biopsy ☐L ☐R ☐B
- ☐ Needle Localization ☐L ☐R ☐B
- ☐ US biopsy ☐L ☐R ☐B
- ☐ Cyst Aspiration ☐L ☐R ☐B
- ☐ MR Biopsy ☐L ☐R ☐B

PET

- ☐ PET/Skull Base to Thigh*
- ☐ PET / Whole Body*
- ☐ PET/Brain Amyvid Alzheimers
- ☐ PET/Brain* ☐ PET/Bone Scan

ULTRASOUND

- ☐ Abdomen
- ☐ Pelvis w/ Transvaginal
- ☐ Aorta
- ☐ Retroperitoneum
- ☐ Scrotum
- ☐ Thyroid

VASCULAR ULTRASOUND

- ☐ Arterial ☐ Venous
  - ☐ Upper Ext.
  - ☐ Lower Ext.
    ☐L ☐R ☐BILAT
- ☐ ABI
- ☐ Insufficiency
- ☐ Carotid
- ☐ Renal Doppler
- ☐ US OTHER (Specify area of interest)

_____

Electronically signed by

California State University, Long Beach
School of Nursing

Physical Exam Form

Last Name: **First:** **MI:**	**DOB:** **ID#:**
Email:	**Phone #** ( ) -
Health Background Information:	
Two Step TB Skin Test Procedure:	
Clinical Screening of TB/Proven Communicable Disease form (found online) must be attached.	

Immunizations proof of immunizations must be attached	**Date**	**Titer Results: Copies of Lab Reports must be attached**
Varicella Vaccination and		
Varicella IgG Quantitative Titer		IgG Titer Immune [ ] Not immune [ ]
Tdap (Tetanus, Diphtheria, Pertussis) Td [illegible]		
MMR Vaccination and		
Rubeola IgG Quantitative Titer and		IgG Titer Immune [ ] Not immune [ ]
Rubella IgG Quantitative Titer and		IgG Titer Immune [ ] Not immune [ ]
Mumps IgG Quantitative Titer		IgG Titer Immune [ ] Not immune [ ]
Hepatitis B Virus [illegible] and	1. 2. 3.	
Hep B Quantitative Titer		IgG Titer ________ Immune [ ] Not immune [ ]
Annual Flu Shot		

Physical Exam Date:
History of back problems/restrictions on lifting: Yes __________ No ________

I have examined the above named student. Based on the health history provided by the student and this physical exam, the student is in good mental and physical condition, and is cleared to work in a health-related field. If any restrictions exist and accommodations are requested, please list them below:

Signature of Health Care Provider: ______________________________________
Physician's Address

Revised [illegible]

McCallum Place Eating Disorder Treatment Programs

Our programs and multiple levels of care provide comprehensive eating disorder treatment and support

Please complete this form so that we can complete our admission screening. Thank you.

Name [illegible] Date of Birth

___/___/___

Date General

Height Weight Temp

Pulse Standing Sitting Blood Pressure Standing Sitting

Skin Heart

Chest Lungs

Abdomen Extremities

Neuro [illegible] [illegible]

Does patient have any [illegible] physical [illegible]

Summary

Application Form for Registration of Clinical Establishments

I.ESTABLISHMENT DETAILS

1.**Name of the establishment**: _____

2.**Address**: _____
Village/Town:_____ Block:_____
District: _____State: _____ Pin code_____
Tel No (with STD code):_____Mobile: _____Fax : _____
Email ID : _____Website (if any): _____

3.**Month and Year of starting**: _____

(From 4 to 11 mark all whichever are applicable)

4. **Location:**
Rural Urban Metro
Notified / inaccessible areas (including Hilly / tribal areas)

5. **Ownership of Services**

Government/Public Sector
Central government State government Local government (Municipality, Zilla parishad, etc)
Public Sector Undertaking Other ministries and departments (Railways, Police, etc.)
Employee State Insurance Corporation Autonomous organization under Government

Non-Government / Private Sector
Individual Proprietorship Partnership Registered companies (registered under central/provincial/state Act) Society/trust (Registered under central/provincial/state Act)

6. **Name of the owner of Clinical Establishment:** _____
Address: _____
Village/Town:_____Block:_____District: _____State: _____ Pin code_____
Tel No (with STD code):_____Mobile: _____Fax : _____
Email ID: _____

7. **Name, Designation and Qualification of person in-charge of the clinical establishment**: _____
Qualification(s): _____
Registration Number: _____
Name of Central/State Council (with which registered): _____
Tel No (with STD code):_____Fax: _____Mobile: _____E-mail ID: _____ __

8. Systems of Medicine offered: (please tick whichever is applicable)
Allopathy Ayurveda Unani Siddha Homoeopathy Yoga Naturopathy Sowa-Rigpa

9. Type of establishment :(please tick whichever is applicable)

(I).**Clinic (Outpatient)**

- Single practitioner
  (Consultation services only/with diagnostic services/with short stay facility)

- Poly clinic
  (Consultation services only/with diagnostic services/with short stay facility)
- Dispensary
- Health Checkup Centre

(II). Day Care facility

Medical Surgical Medical SPA Wellness centers (where qualified medical professionals are available to supervise the services).

(III). Hospitals including Nursing Home (outpatient and inpatient):

- Hospital Level 1 a
- Hospital Level 1 b
- Hospital Level 2
- Hospital Level 3 (Non teaching)
- Hospital Level 4 (Teaching)

(IV). Dental Clinics and Dental Hospital:

a. Dental clinics

i. Single practitioner
ii. Poly Clinics (dental)

b. Dental Hospitals (specialties as listed in the IDC Act.)

i. Oral and maxillofacial surgery
ii. Oral medicine and radiology
iii. Orthodontics
iv. Conservative dentistry and Endodontics
v. Periodontics
vi. Pedodontics and preventive dentistry
vii. Oral pathology and Microbiology
viii. Prosthodontics and crown bridge
ix. Public health dentistry

(V).Diagnostic Centre

A. Medical Diagnostic Laboratories:

Pathology Biochemistry Microbiology
Molecular Biology and Genetic Labs Virology

B. Diagnostic Imaging centers

i. Radiology

- General radiology
- Interventional radiology

ii. Electromagnetic imaging

- Magnetic Resonance Imaging (MRI),
- Positron Emission Tomography (PET) Scan

iii. **Ultrasound**

C. Miscellaneous

- Electro Cardio Graphy(ECG)
- Tread Mill Test
- Electro Encephalo Graphy(EEG)
- Mammography
- Echocardiography
- Electro MyoGraphy (EMG)
- Electrophysiological studies

D. **Collection centers**

For the clinical labs and diagnostic centres shall function under registered clinical establishment

Yes/No

if Yes, then No of Collection Centre: ☐

(VI). Allied Health professions:

- Audiology
- Behavioral health (counseling, marriage and family therapy etc)
- Exercise physiology
- Nuclear medicine technology
- Medical Laboratory Scientist
- Dietetics
- Occupational therapy
- Optometry
- Orthoptics
- Orthotics and prosthetics
- Osteopathy
- Paramedic
- Podiatry
- Health Psychology/ Clinical Psychology
- Physiotherapy
- Radiation therapy
- Radiography / Medical imaging
- Respiratory Therapy
- Sonography
- Speech pathology

(VII) AYUSH

Ayurveda

Ausadh Chikitsa Shalya Chikitsa Shodhan Chikitsa Rasayana Pathya Vyavastha

Yoga

Ashtang Yoga

Unani

Matab Jarahat Ilaj-bit-Tadbeer Hifzan-e-Sehat

Siddha

Maruthuvam Sirappu Maruthuvam Varmam Thokknam & Yoga

Homoeopathy

General Homoeopathy

Naturopathy
External Therapies with natural modalities Internal Therapies

II.TYPES OF SERVICE

- **TYPE**

General Practice Services
Single Specialty Services
Multi Specialty Services (including Palliative care Centre, Trauma Centre, Maternity Home - applicable for hospitals only)
Super Specialty Services

- **SPECIALITY SPECIFIC**

Medical Specialties – for which candidates must possess recognized PG degree (MD/Diploma/DNB or its equivalent degree)

i. Anesthesiology
ii. Aviation Medicine
iii. Community Medicine
iv. Dermatology, Venerology and Leprosy
v. Family Medicine
vi. General Medicine
vii. Geriatrics
viii. ImmunoHaematology and Blood Transfusion
ix. Nuclear Medicine
x. Paediatrics
xi. Physical Medicine Rehabilitation
xii. Psychiatry
xiii. Radio-diagnosis
xiv. Radio-therapy
xv. Rheumatology
xvi. Sports Medicine
xvii. Tropical Medicine
xviii. Tuberculosis & Respiratory Medicine or Pulmonary Medicine

Surgical specialties - for which candidates must possess, recognized PG degree (MS/Diploma/DNB or its equivalent degree)

i. Otorhinolaryngology
ii. General Surgery
iii. Ophthalmology
iv. Orthopedics
v. Obstetrics & Gynecology

Medical Super specialties –
i. Cardiology
ii. Clinical Hematology including Stem Cell Therapy
iii. Clinical Pharmacology

iv. Endocrinology
v. Immunology
vi. Medical Gastroenterology
vii. Medical Genetics
viii. Medical Oncology
ix. Neonatology
x. Nephrology
xi. Neurology
xii. Neuro-radiology

Surgical Super-specialities-

i. Cardiovascular thoracic Surgery)
ii. Urology
iii. Neuro-Surgery
iv. Paediatrics Surgery.
v. Plastic & Reconstructive Surgery
vi. Surgical Gastroenterology
vii. Surgical Oncology
viii. Endocrine Surgery
ix. Gynecological Oncology
x. Vascular Surgery

III INFRASTRUCTURE DETAILS

10. **Area of the establishment** (in sqft):
a) Total Area: _____b) Constructed area: _____

11. **Out Patient Department:**
11.1 Total no. of OPD Clinics: _____

11.2 Specialty-wise distribution of OPD Clinic

S.No.	Specialty

12. **In Patient Department:**
12.1. Total number of beds: _____
12.2. Specialty-wise distribution of beds, please specify:

S.No.	Specialty	Beds

13. **Biomedical waste Management**
13.1 **Method of treatment and /or disposal of Bio-medical waste**
☐ Through Common Facility ☐ Onsite Facility
☐ Any other (please specify): _____

13.2.**Whether authorization from Pollution Control Board/Pollution Control Committee obtained**?

☐ Yes ☐ No ☐ Applied For ☐Not Applicable

IV HUMAN RESOURCES

14. **Total number of Staff (as on date of application):**
No. of permanent staff:_____ No. of temporary staff: _____

Please furnish the following details:-

Category of staff	**Name**	**Qualification**	**Registration No**	**Nature of service Temporary/ Permanent**
Doctors				
Nursing staff				
Para-medical staff				
Pharmacists				
Administrative staff				
Others, please specify				

Separate annexure may be attached.

Support Staff

Category	Total no.	Remark

15. **Payment options for Registration Fees:**
☐ Online payment☐ Demand Draft Bank Challan

Amount (in Rs):_____
Details: _____
Receipt No._____

I,. .....on behalf of myself and the company/ society/association/body hereby declare that the statements above are correct and true to the best of my knowledge and I shall abide by all the provisions made under the Clinical Establishment (Registration and Regulation) Act 2010.
I undertake that I shall inform the DistrictRegistering Authority of any changes in the particulars given above.
I shall comply with the minimum standards prescribed under Clinical Establishment Act for the services provided by us and also all other conditions of registration as stipulated under the aforesaid Act and Rule there-under.

Place: Signature of the Authorized Signatory
Date: Office Seal

Medical Report

Full Name: _____ Date of Birth: _____

Please answer 'yes' or 'no' to the following questions. If in doubt consult your doctor.

If answering 'yes' on any point give details below. Use a separate sheet if necessary.

1. Do you have recurring / ongoing problems in the following areas?

Headaches	_____	Epilepsy / Fits	_____
Earaches	_____	Diabetes	_____
Sore Throats	_____	High Blood Pressure	_____
Sinus Trouble	_____	Fainting Episodes / Blackouts	_____
Toothache	_____	Back, Neck or Joint Problem	_____
Eye Strain	_____	Stomach Upsets	_____
Dyslexia	_____	Bladder Trouble	_____
Asthma	_____	Tenosynovitis / R.S.I.	_____
Hay Fever	_____	Depression/Nervous Illness/ Mental Disorder	_____
Skin Condition	_____	M.E. (Myalgic Encephalomyelitis) / Chronic Fatigue Syndrome	_____
Allergy	_____	Anorexia/Bulimia	_____

HEALTHCARE

Patient: Herks Viols (04/27/1994 - 31y), Male
Address: Mountainview Dr Boardman, OR 97818
Phone: (402) 456-5432
Seen On: 12/16/2025

Seen At: DoseSpotClinic
Address: 123 N Main St str 2
Brooklyn, MI 49230
Phone: (956) 825-0925
Fax: (332) 241-0212
Provider:

Chief Complaint

Asthma
Source: Self

Vitals

Vitals:
Air Source: Room Air

Set 1:

History of Present Illness

No history of present illness data entered

PAST MEDICAL HISTORY

Allergies

No allergies entered

Medication

No medications entered
36RK
406 SMART DRIVe
CAYTON, AL 36016
Phone: (412) 370-4500
Fax: (412) 980-4567

Immunization

No immunizations entered

Surgical History

No surgical history entered

Medical Condition

No past medical history entered

Preventative Med Notes

No preventativeMedNotes entered

HEALTHCARE

Patient: Herks Viols (04/27/1994 - 31y), Male
Address: Mountainview Dr Boardman, OR 97818
Phone: (402) 456-5432
Seen On: 12/16/2025

Seen At: DoseSpotClinic
Address: 123 N Main St str 2
Brooklyn, MI 49230
Phone: (956) 825-0925
Fax: (332) 241-0212
Provider:

Social History

No social history entered

Family History

No family history entered

Review of Systems

No review of systems data entered

Exam

No examination data entered

Orders & Procedures

No procedures entered
Lab Requests:
BRUICE BASIC FEMALE

Assessment/Plan

No assessment plan entered

External Orders:
Order File: Herks Viols Order to TestingLab Facility 12/16/2025.pdf
Result: BRUICE BASIC FEMALE

Prescription

Signature

Addendums