



**Name of Recipient Organization:**

**Contact name:**

**Title:**

**Address:**

**City:**  **State:**

**Zip Code:**  **Country:**

**Phone:**  **Fax:**

**E-mail:**  **Website Address**  **Dedicated line?**  Yes  No

**Name of hospital/clinic receiving assistance:**

**Who owns/operates the facility?**

**Contact name:**

**Title:**

**City:**  **State:**

**Zip Code:**  **Country:**

What is the legal status of the facility?

- Private, for-profit
- Public/government

- Private, not-for-profit
- Religious. Affiliation: \_\_\_\_\_

How long has this facility been operational?

Does the facility have internet access?  Yes ( Dial-up  DSL/Cable)  No

Facilities Annual budget      National currency \$ \_\_\_\_\_      US Dollars \$ \_\_\_\_\_

Actual expenditure for Medical Supplies and Equipment

National currency \$ \_\_\_\_\_      US Dollars \$ \_\_\_\_\_

Describe funding of hospital (i.e. fee for service, donor, government, etc.):

Please indicate the type of facility and number of beds:

- Urban      or       Rural      # of beds: \_\_\_\_\_
- Hospital      or       Clinic or  Other (please describe):

What is the total number of staff at the facility?

How many of each of the following are there?

- \_\_\_\_\_ Physicians      \_\_\_\_\_ Traditional healers      \_\_\_\_\_ Midwives
- \_\_\_\_\_ Lab Technicians      \_\_\_\_\_ Nurses      \_\_\_\_\_ Dentists
- \_\_\_\_\_ Nutritionists      \_\_\_\_\_ Anesthesiologists      \_\_\_\_\_ Surgeons
- \_\_\_\_\_ Biomedical technicians      \_\_\_\_\_ Nurse Anesthetists
- \_\_\_\_\_ Community Health Workers

Total number patients treated per month:

Men: \_\_\_\_\_ Women: \_\_\_\_\_ Children: \_\_\_\_\_

Type of medical services provided at the facility:

- |  |   |                                      |  |   |
|--|---|--------------------------------------|--|---|
| <input type="checkbox"/> Primary Health Care     | <input type="checkbox"/> Gynecology     | <input type="checkbox"/> Surgery     | <input type="checkbox"/> Pediatrics    | <input type="checkbox"/> Obstetrics           |
| <input type="checkbox"/> Intensive care          | <input type="checkbox"/> Immunizations  | <input type="checkbox"/> Orthopedics | <input type="checkbox"/> X-ray/Imaging |   |
| <input type="checkbox"/> Health education        | <input type="checkbox"/> Eye care       | <input type="checkbox"/> Dental      |  | <input type="checkbox"/> Nutritional services |
| <input type="checkbox"/> Ear, nose, throat       | <input type="checkbox"/> Mental health  | <input type="checkbox"/> Traditional | <input type="checkbox"/> Laboratory    |   |
| <input type="checkbox"/> General medicine        | <input type="checkbox"/> Emergency care | <input type="checkbox"/> medicine    |  |   |
| <input type="checkbox"/> Other. Please describe: |   |                                      |  |   |

What are the major health problems treated at your facility?

What characteristics below best describe the end user facility?

Sterilization:

- Gas sterilization process       Steam/heat sterilization process       Other. Please specify:

What is the estimated population of the geographic area served?

Please describe the population and environment of the area with regard to livelihood, language, cultural history, etc.:

What are the primary causes of mortality in your area?

Is patient treated if not able to pay for care?

- Yes       No       Require at least partial payment

What do you currently do with equipment that does not work?