



Physiotherapy Centers Information Sheet

I- LEGAL INFORMATION

Name of the Physiotherapy Center _____

Name of Owner (s) _____

Name of Physiotherapist in charge:

First Name Middle Name Maiden Name Family Name
(before marriage)

Diploma _____

School _____ , **Graduation year** _____

MOH License for Opening a Physiotherapy Center:

License Number _____ **Date** _____

MOH License for practicing Physiotherapy:

License Number _____ **Date** _____

Year of establishment of the Center _____

II- ADMINISTRATIVE INFORMATION

A- Address

Country _____

Region _____

City _____

Street _____

Building _____

Floor _____

Telephone # _____

Cellular # _____

Fax # _____

P.O. Box _____

E-mail _____

Website <http://> _____

B- Working days and hours

<i>Days (From – To)</i>	<i>Hours (From – To)</i>
_____	_____
_____	_____
_____	_____

C- All physiotherapists in the Center (including physiotherapist in charge)

<i>First Name</i>	<i>Middle Name</i>	<i>Family Name</i>	<i>In which hospital do they practice? (specify if any)</i>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

D- Other employees

<i>Position</i>	<i>Number of employees</i>
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_____	_____
_____	_____
_____	_____

Please identify:

The name(s) of the employees(s) to operate MedNet programs:

The name(s) of the employee(s) responsible for receiving patients:

F- Others

Accessories

Do you have:

Computer *Yes* *No*, *If yes, how many?* _____

Printer *Yes* *No*, *If yes, how many?* _____

Modem *Yes* *No*, *If yes, how many?* _____

Photocopy Machine *Yes* *No*, *If yes, how many?* _____

Credit Card Reader *Yes* *No*, *If yes, how many?* _____

Please fill in where available

Which Microsoft Windows Version? *Win95* *Win98*

Do you have an internet account? *Yes* *No*

Which Browser do you use? *Internet Explorer* *Netscape* *Other*

Do you accept any of these cards? *Visa* *Master* *American Express* *Link*
Others, Specify _____

Facilities

Area of the Center _____ *(m2)*

Number of Rooms _____

Do you have:

Parking *Yes* *No*

If yes, Briefly describe where? _____

Elevator in the Building *Yes* *No*

Waiting Room *Yes* *No*

Conference Room *Yes* *No*

Statistical information (yearly work load, number of patients, number of services, etc.)
(Optional)

<i>Description</i>	<i>Number</i>
_____	_____
_____	_____
_____	_____

<i>Kindly attach if present</i>		
<i>Map to the center (Sample Attached)</i>	<input type="checkbox"/> <i>Yes</i>	<input type="checkbox"/> <i>No</i>
<i>Picture of the Center</i>	<input type="checkbox"/> <i>Yes</i>	<input type="checkbox"/> <i>No</i>
<i>Logo</i>	<input type="checkbox"/> <i>Yes</i>	<input type="checkbox"/> <i>No</i>
<i>Organigram of the Center (by position)</i>	<input type="checkbox"/> <i>Yes</i>	<input type="checkbox"/> <i>No</i>

<i>III- HOME SERVICES</i>		
<i>Do you Offer</i>		
<i>Physical therapy services at houses</i>	<input type="checkbox"/> <i>Yes</i>	<input type="checkbox"/> <i>No</i>
<i>Within Which areas ? _____</i>		

<i>IV- SERVICES (please check "3" where available)</i>		
<i>Service</i>		<i>Availability</i>
Massage Therapy / Massage		
Respiratory Reeducation/ Reeducation respiratoire		
Pressotherapy/ Pressotherapie		
Cervical traction/ Traction cervicale		
Lumbar traction/ Traction lombaire		
Manual lymphatic drain. / Drainage lymphatique manuel		
Passive mobilization/ Mobilizations Passives		
Active mobilization / Mobilizations Actives		
Laser therapy / laser Therapie		
Gynecologic machine / appareillage Gynecologique		
Pulley therapy / Poulie therapie		
Proprioceptive reeducation/ Reeducation proprioceptive		
Ludo therapy / Ludo Therapie		
Thermal Therapy / Thermotherapie	Infra Red / Infra Rouge	
	Thermophore	
	Paraffine therapy / Paraffino Therapie	
Cryotherapy / Cryotherapie	Machine / Appareil	
	Cold pack / Vessie de Glace	
Mascular Reinforcement/ Renforcement Musculaire	Reinforcement	
	Electro-Myo—Stimulation (EMS)	
	Myofeedback	
	Isocinetism / Isocinetisme	
Hydrotherapy	Pool / Piscine	
	Jacuzzi	
	Water jet Therapy / Jets d'eau	

Date:

Signature & Stamp:

**المستندات المطلوبة من قبل شركة مدنت لبنان
للاضمام الى شبكة مراكز العلاج الفيزيائي**

١- تعبئة نموذج (Information Sheet) المتوفر لدى شركة مدنت لبنان

٢- صورة عن اجازة ممارسة مهنة العلاج الفيزيائي.

٣- صورة عن اجازة فتح وساتثمار مركز العلاج الفيزيائي.

٤- صورة عن بطاقة الانتساب الى النقابة (صالحة).

٥- خريطة بالغرف التي يشغلها المركز.

٦- لائحة التجهيزات الفنية.