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வட மேல் மாகாண சுகாதார சேவைகள் திணைக்களம்
Department of Health Services – North Western Province



ක. පෙ. 84, සෞඛ්‍ය සංකීර්ණය,
මීගමු පාර,
කුරුණෑගල. 60000

தபாற்பெட்டி 84, சுகாதார வளாகம்
நீர்கொடும்பு வீதி
குருநாகல் 60000

P.O. Box 84, Health Complex,
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මගේ අංකය NWP/PDHS/AD(TEC)/BM1/ 01/2025
எனது இல
Mv No

මගේ අංකය
உமது இல. :
Your No

දිනය
திகதி : 2025.10. 18
Date

Internal Circular: NWP/PDHS/07/2025

Regional Directors of Health Services- Kurunegala/Puttalam

All Medical Superintendents - NWP

All Divisional Medical Officers - NWP

Requests for Upgrading of Medical Equipment

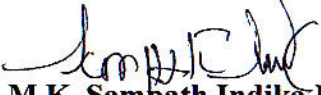
You are hereby instructed to proceed upgrading of medical equipment in your respective institutions, in accordance with the guidelines outlined below.

To facilitate this process, you are instructed to follow the **Medical Equipment Upgrading Request Form** (Format No: NWP/PDHS/BM/17/85), formulated to align with the provincial set-up. (The relevant form is attached herewith.)

Submit the **soft copy** of this form via your official email to ad.tec.pdhsnwp@gmail.com with the subject line: "**Upgrading Medical Equipment – Year**" (ex-: "Upgrading Medical Equipment – 2025"). In addition, ensure that a **hard copy** is sent to the **PDHS office** via postal mail with RDHS recommendation.

I hereby instruct all relevant institutions in the North Western Province to utilize this format when submitting equipment upgrade requests.

Only submissions using the prescribed format will be accepted. Requests submitted in any other means will not be considered.


Dr. M.K. Sampath Indika Kumara
Provincial Director of Health Services
North Western Province

Dr. M.K. Sampath Indika Kumara
MBBS, MSc MD, MCMA
Provincial Director of Health Services
North Western Province
Kurunegala.

Copies-:

1. Director General of Health Services, Ministry of Health, Sri Lanka.
2. Secretary, Ministry of Health, North Western Province.
3. Chief Accountant, Office of Provincial Director of Health Services, North Western Province.

Medical Equipment Upgrading Request Form

(All the questions must be answered)

1. Details of the Institution

RDHS

Institution

Department / Section

2. New Request

(i) Equipment Name

(ii) Specify Special Need

(iii) Justification

(iv) Estimated Cost, if any Rs.

3. Existing Equipment

Yes No

(i)

| Make | Model | Installed Year | Working Condition |
|------|-------|----------------|---|
| | | | Working/Working with frequent repair /Sent for repair/Condemned/ Other(specify) |

(ii) Performance : Monthly Average

| Work Performance | No. |
|-------------------------|--|
| e.g. Endoscopy ----- | No of investigation performed ----- |

4. Infrastructure

| Need | Status | | Comments |
|------------------|--------|----|----------|
| | Yes | No | |
| Space | | | |
| Power | | | |
| Water | | | |
| Waste Disposal | | | |
| A/C | | | |
| Humidity Control | | | |

5. Human Resources

| Designation | In position |
|-------------|-------------|
| Consultant | |
| MO | |
| MLT | |

6. Operational and Maintenance Arrangements

- (i) Funding Source – Provincial / Line Ministry
- (ii) Authorizing Entity - Provincial Director of Health Services
- (iii) Reagent Cost - Provincial

To be completed by Chief Pharmacist of the Hospital

I certify that the above information is true and correct.

Signature of the Chief Pharmacist of the Hospital

.....

(Official stamp)

Date:

To be completed by Director/Medical Superintendent of the Hospital/Head of the institution

I certify that the above information is true and correct.

Recommended and forwarded

Signature of the Director/MS of the Hospital/Head of the institution
(Official stamp)

Date:

To be completed by Regional Director of Health Services

Recommended and forwarded / Not Recommended

Signature of the RDHS
(Official stamp)

Date:

Office use only

To be completed by Assist. Director (Medical Supply, Laboratory Services & Biomedical Technology)

Recommended & forwarded / Not Recommended

Signature of the Asist. Director (Medical Supply,
Laboratory Services & Biomedical Technology)
(Official stamp)

Date.....

To be completed by Provincial Director of Health Services

Recommended & forwarded / Not Recommended/Approved /Not Approved

Signature of the PDHS
(Official stamp)

Date: