Report Overview for The Month of ,2026

Name/ID:
Designation:

Visited District:
Total Visited Doctor:
Total Visited Management and related Person:
Obtained Requirement info:
X-ray: Requirement: _____, Offered: _____
Ultrasound: Requirement: _____, Offered: _____
C-Arm: Requirement: _____, Offered: _____
CT scan: Requirement: _____, Offered: _____
OPG: Requirement: _____, Offered: _____
Mammography: _____, Offered: _____

Comment:

Area Name:

Organization Name & Address	Physician/ KOL	Contact Details	Current usage	Requirement	Comment