INDIVIDUAL / FAMILY MEDICAL SERVICES REGISTRATION FORM

DETAILS OF PRINCIPAL APPLICANT

NAME OF PRINCIPAL APPLICANT	
NRC NUMBER	
CONTACT DETAILS	
EMAIL ADDRESS	
PHYSICAL ADDRESS	
NEXT OF KIN	
NUMBER OF PEOPLE TO BE ON THE SCHEME	

LIST OF MEMBERS TO RECEIVE MEDICAL SERVICES ON THIS SCHEME

Name	Date of Birth	NRC / Identity No.	Mobile Number	Physical Address

***Additional names can be attached to the application form, if the space provided is not adequate

ACKNOWLEDGEMENT BY APPLICANT

I ………………………………………….. Acknowledge that the information given above is correct.

Name: …………………………………. Sign: …………………………………. Date: ……………...

	MOPANI COPPER MINES PLC MEDICAL DEPARTMENT FM-ME-573 INDIVIDUAL / FAMILY MEDICAL SERVICES REGISTRATION FORM

FOR OFFICIAL USE

Application received by: ……………………………… Sign: …………………… Date: ……………..

VERIFICATION by SENIOR / HOSPITAL ADMINISTRATOR

COMMENT ……………………………………………………………………………

Name: ………………………………… Sign: ………………………………… Date: ……………...

MEDICAL MANAGER / MEDICAL SUPERINTENDENT APPROVAL (Tick)

Approved ☐ Rejected ☐

Reason for Rejections:…………………………………………………………………………

Name: ………………………………… Sign: ………………………………… Date: ……………...

CLIENT COMMUNICATION

Client informed by: Phone ☐ Email ☐ Official Letter ☐

Name: ………………………………… Sign: ………… ……………………… Date: ……………...

ACCOUNTANT

Mode of Payment: Cash ☐ Cheque ☐ Telegraphic Transfer ☐ Other:………..

Amount paid: ……………………………………… Comment: ……………………………………

Name:………………………………… Sign: ………………………………… Date: ……………...

HMIS SYSTEM REGISTRATION

Registration completed by: …………………………………………… ID No : …………………

Date: …………………………………………… Signature: ………………………………………