ParkCity Medical Centre

Membership Application Form

Child

Full Name: _____

Age: _____

Date of birth: _____

Hospital of birth: _____

MyKID No.: _____

Birth Certificate No.: _____

Passport No.: _____

Gender: _____

MRN Number: _____

Mother's / Father's information

Full Name: _____

MyKad No.: _____

Passport No.: _____

Nationality: _____

Address: _____

_____

Mobile No.: _____

Email address: _____

Emergency Contact

Name: _____

Mobile No.: _____

Relationship: _____

Please Indicate Your Preferred Membership Card Option: ☐ e-Wallet Card or ☐ Physical Card

Others

Temporary / Permanent Card No.: _____

Privacy & Personal Data Protection Policy

☐ I hereby allow my personal data to be processed for purposes stated in CAH Medical Centres Sdn Bhd (CMC) (formerly known as Ramsay Sime Darby Health Care Sdn Bhd) Registration No.: 201301008653 (1038495-A) Privacy and Personal Data Protection Policy which is accessible at https://parkcitymedicalcentre.com/privacy-and-pdpa-policy.

☐ I hereby agree to receive marketing materials from ParkCity Medical Centre.

Signature: _____ Name: _____ Date: _____