

MEMBERSHIP APPLICATION FORM

APPLICANT'S INFORMATION

SUBMIT your completed form during office hours from Mon - Fri to the **Customer Care reception**, Ground Floor (lobby), PMC.

Full Name:

Title:

Medical Record Number (MRN):

Age:

Date of Birth:

MyKad No. / Passport No.:

Gender:

Nationality:

Address (in Malaysia): _____

Mobile Number:

Email: _____

If you do not have an email address, please provide a valid and active email address of your family members.

PLEASE INDICATE YOUR PREFERRED MEMBERSHIP CARD OPTION:

☐ e-Wallet Card or ☐ Physical Card

EMERGENCY CONTACT

Name:

Mobile Number:

Relationship:

For more information, please refer to [bit.ly/pmcseniors](https://parkcitymedicalcentre.com/privacy-and-pdpa-policy). Please refer to programme flyer or our website for full Terms and Conditions.

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.

Name:
Date: