



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 INFORMATION

Full Name: _____
MyKad No.: _____
Passport No.: _____
Nationality: _____
Address: _____

Mobile No.: _____
Email address: _____

EMERGENCY CONTACT

Name: _____
Mobile No.: _____
Relationship: _____

OTHERS

Temporary / Permanent Card No.: _____

PRIVACY & PERSONAL DATA PROTECTION POLICY

- ☐ I hereby allow my personal data to be processed for purposes stated in Ramsay Sime Darby Health Care ("RSDH") Privacy and Personal Data Protection Policy which is accessible at <https://www.ramsaysimedarby.com/personal-data-protection-notice>.
- ☐ I hereby agree to receive marketing materials from RSDH.

Name:
Date: