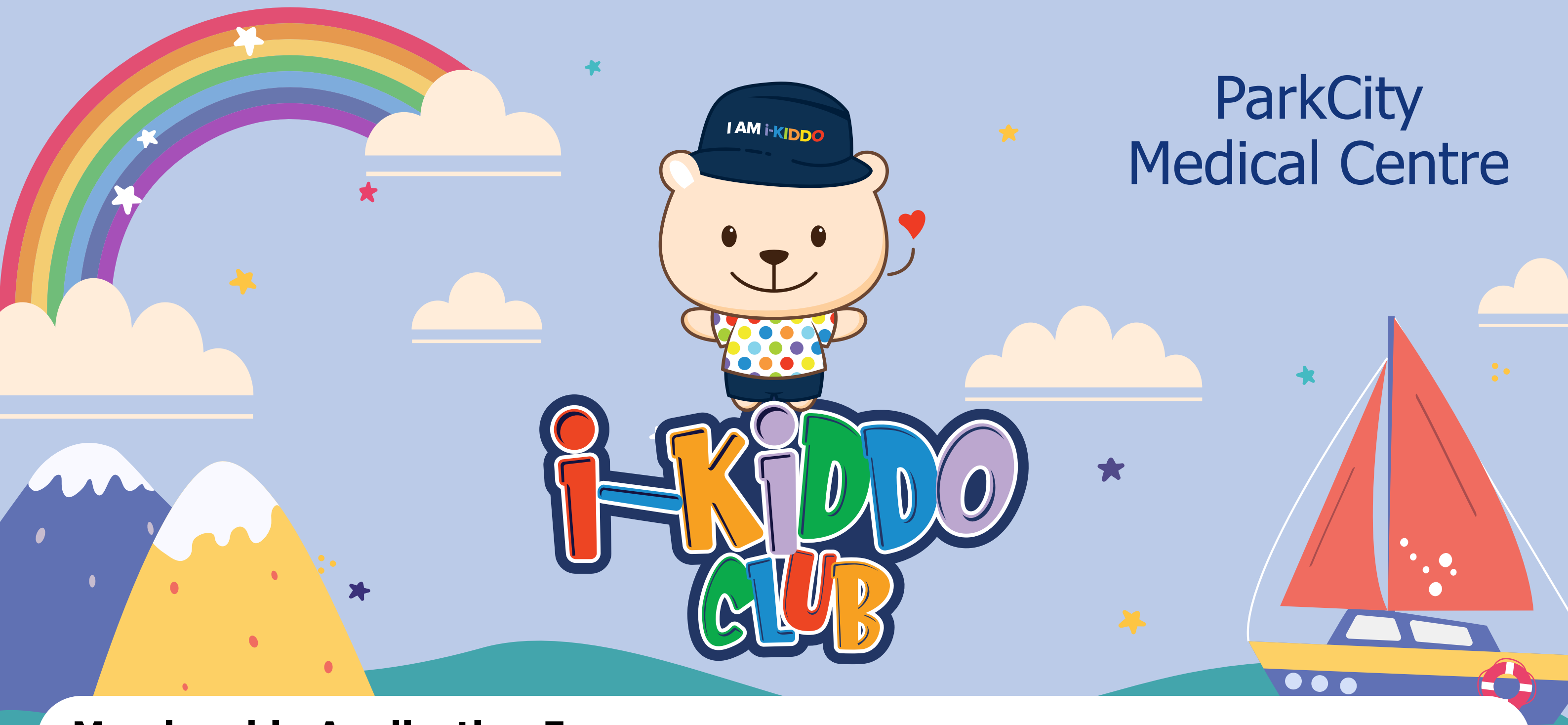

Membership Application Form

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: ______

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

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: ______