



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://aradamansaramedicalcentre.com/privacy-and-pdpa-policy>.
- ☐ I hereby agree to receive marketing materials from Ara Damansara Medical Centre.

Signature: _____ Name: _____ Date: _____