FPSA LOCAL MEDICAL CONSULTANCY SCHEME

APPLICATION FORM – FPSA MEDICAL CARD

Attach 1 Passport Photos 2.5cm * 2.5cm

PERSONAL INFORMATION.

FULL NAME OF MEMBER (Mr./Mrs./Ms)

.....

MINISTRY/DEPARTMENT

.....

JOB TITLE

.....

STATION .....

DATE JOINED SERVICE: .....

DATE JOINED MEMBERSHIP ..... :

.

RESIDENTIAL ADDRESS:

…….

.....

.....

PHONE NO: (RESIDENCE):.....

:(WORK): .....

DATE OF BIRTH ……..

EDP/FNPF/EMP NO:……..

SPOUSE FULL NAME (Mr. /Mrs.)

.....

SPOUSE DATE OF BIRTH……

DATE OF MARRIAGE .....

[THIS SECTION FOR SINGLE MEMBERS]

FATHER'S NAME:……....

MOTHER'S NAME:……..…

****(attach birth certificate)***

Name of Child (age<18yr)	Gender (M/F)	Date of Birth
.....	.....	.....

NOTE:

- Spouse and children when seeking medical treatment should carry FPSA Medical ID card.
  Please attach your Marriage Certificate and your children's birth certificate.
  (children eligibility is from below 18years, eligible provided the child is single and wholly dependent on the member).

I certify that the particulars and information given above are true and correct in every respect.

Signature of Member: ..... Date:.....

Signature of Spouse .....

ID CARD NO: ..... RECEIVED BY:.....