MINISTRY OF HEALTH

(seal)

THE STATE MEDICAL INSTITUTIONS AND SERVICES GENERAL REGULATIONS (CLR.225/2000 and 660/2002)

APPLICATION FOR MEDICAL IDENTITY CARD AND DECLARATION OF INCOME (REGULATION 5)

PERSONAL DETA	ILS OF AFFLIC	<u> </u>	F	OR OFFICIAL I	JSE
'Name:Surname:			Reference Number		
Date of Birth:/Identity Card no.:			Medical Identity ca	ard approved:	
Gender: Male Electoral Book No.:			First Schedule :		
Female Social S	Security No.:		The Medical//200	Identity Card	is valid until
Address:		Medical identity	card issue is not	approved due to	
Town/Village:Area Code:					
District:Home Tel.:					
		Full name:			
For those holding a medical identity card		Title:			
Medical Identity card no:		Signature:			
Date of expiry:			Date:/200		
• •			Inspected by:		
Married status:		Full name:			
Married/ or Head of large family		Title:			
Single		Signature:/200			
Divorced/ or Dependant of Separated Missing person					
Widow/er Member of enclaved family	d				
APPLICANT'S DEPENDANTS		P	ART II: DE	TAILS OF	
Name	Identity Card no.	Date of Birth	Gender M/F	Social Security no.	Electoral Book no.
(Of spouse)		//			
(Of dependant children under 18))					
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PART III: FAMILY INCOME

A. Income from Work

Professional Details	Details of Last Employer	Anı Gr Incom W	
Of Applicant:			
Occupation:	Name/Business Title		
☐ Salaried/or Self employed/or	Address	£	
☐ Pensioner			
Of Spouse:			
	Nama/Duainaga Titla		
Occupation:	Name/Business Title		
☐ Salaried/or			
☐ Self employed/or	Address	£	
Pensioner			
	Tel		
Dependant Children in Employment		T	
Name:			
	Name/Business Title		
Occupation:			
<u></u>	Address		
☐ Salaried/or ☐ Self employed			
Seil employed	Tel		
Name:			
	Name/Business Title		
Occupation:	Address		
☐ Salaried/or			
☐ Self employed			
	Tel	£	
B. Annual Gross Income from per	nsions and other sources:	Income	

	Pensions: (1) Social Security	
	(2) Social Pension	
	(3)	
	Rent/Interest/Dividends	
	Other income	
		TOTAL FAMILY INCOME
		health insurance:YES/NO.If «yes» state:
	DE	<u>ECLARATION</u>
ac th in	entained in this statement as well as ecompanying this application are true e Ministry of Health to seek confirma	entity Card and declare that all the details the certificates and other documents and correct and that I permit the Services of ation from various Government Services, ment, regarding the information and documents of my dependants.
*	I further declare that both I and my s Do not submit tax returns and to da come Tax Law	spouse— ate have not been taxed in pursuance of the
	The last year for which I/we subminuw was	tted tax returns in pursuance of the Income Tax
*	Delete where non applicable	
Si	Date.://200 gnature:	

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