SCHEDULE 2

Regulations

FORM OF APPLICATION
GIBRALTAR HEALTH AUTHORITY
MEDICAL (GROUP PRACTICE) SCHEME

Application for Registration

Please fill in the following details:

Surname:_____

First Name: _____Initial(s):_____

Address: _____

Nationality:_____

Tel No: _____ Date of Birth: _____ Sex: _____

No. of dependants: _____ I D No: _____

Doctor: _____ Blood Group: _____

Are you diabetic? Yes / No Are you a blood donor? Yes / No

I of
Hereby declare that the above particulars are true to the best of my knowledge and belief. I acknowledge that it is an offence wilfully to make any false statement or any material misrepresentation in this application, with the intention of obtaining or attempting to obtain any benefit which I or any of my dependants are not entitled.

DATE: _____ SIGNATURE:_____

Please complete a form in respect of each of the dependants for whom an application for registration is being made.

Please produce when registering, the following documents (if applicable):

a) Social Insurance – Obtainable either from employer or Contributions Unit
b) Civilian Registration Card / Passport
c) Permit of residence (if applicable)
d) Work Contract (ETB)
e) 1 Passport sized colour photo

Collected By: _____ Issued By: _____