PHYSICAL HEALTH
& HEALING CENTER

Ibn Al Thahabi Building #24, 2nd Floor
Dubai Health Care City
Phone: 04 552 9210 / 052 8269454
Email: contact@phhc-dhcc.com

Naturally Efficient

Your trusted family's
Osteopathic Health Center

Specialized in :
- Neonates, Infants, Childs
- People of Determination
- Seniors & Elders

SOCIAL SUPPORT BENEFICIARY APPLICATION FORM

Social support to the most needful people and communities falls under PHHC Osteopathic center's Corporate Social Responsibility (CSR).
As such, any individual can apply by filling out this form and providing request documents.
Each case will be review for eligibility by PHHC Osteopathic center's Management.

DOCUMENTS REQUIRED TO OPEN A FILE

- ❑ One Personal Photo
- ❑ Copy of Residency Visa Page
- ❑ Passport Copy OR Copy of National ID
- ❑ Insurance Card Copy
- ❑ Medical Report (lesser than6 months)
- ❑ Letter Explaining the case.
- ❑ Rent Contract or Ejari certificate.
- ❑ Attested Salary Certificate
- ❑ Attested 3 months bank statement.
- ❑ Guardian Legal Tutor - Passport Copy

HEAD OF THE FAMILY PERSONAL DETAILS

Family name :
Full Name :
Date of Birth :
Marital Status:
Nationality :
Gender :
Qualification :
Occupation :
Emirates ID number :

FAMILY FINANCIAL DETAILS

Total Family Members :
Total Family Income:
No. of Family Members Working :
Yearly Rent expense:
Average Family Monthly expense *(Without Rent)*:

FAMILY RESIDENCY DETAILS

Residency Visa Number :
Residency Visa Expiry Date :
Type of Accommodation :
Area :
Emirate :
Mobile Number :
Work Phone Number:
Personal Email :
Sponsor Phone Number :
Professional Email:
Sponsor Name :
Number of years in the UAE:

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Are you applying for a family member or for yourself?

HEALTH DETAILS ***(of the person you are applying for)***

Full Patient's Name
Relation *(if your are not the patient)*:
Type of Disease
Date of Diagnosis:
Type of Treatment
Place of Treatment:
Health Insurance Provider:
Health Insurance Expiry Date:
Health Card Expiry Date:

TREATING DOCTOR'S DETAILS

Full Name:
Contact N°:
Email:
Establishment/Clinic:

REFERRING DOCTOR'S DETAILS ***(only if you have been referred)***

Have you been referred by another doctor?
If yes, please fill the follow fields

Full Name:
Contact N°:
Email:
Establishment/Clinic:

EMERGENCY CONTACT PERSON DETAILS

Full Name:
Relation:
Phone N°:

I hereby confirm that all information and related documents I have provided are accurate.

Applicant Name:
Date:
Signature:

For internal use only

Patient MR-N°:
Eligibility:
Management comments & Approval:

Date:
Signature :