



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

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| <input type="checkbox"/> One Personal Photo | <input type="checkbox"/> Letter Explaining the case. |
| <input type="checkbox"/> Copy of Residency Visa Page | <input type="checkbox"/> Rent Contract or Ejari certificate. |
| <input type="checkbox"/> Passport Copy OR Copy of National ID | <input type="checkbox"/> Attested Salary Certificate |
| <input type="checkbox"/> Insurance Card Copy | <input type="checkbox"/> Attested 3 months bank statement. |
| <input type="checkbox"/> Medical Report (lesser than6 months) | <input type="checkbox"/> 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 (<i>Without Rent</i>):	

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:	



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:
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For internal use only

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