

PANEL APPLICATION FORM

PART A – CLINIC INFORMATION

Clinic Name: _____

Clinic Address: _____

State: _____

Postcode: _____

Email Address: _____

Perkeso Panel: ☐ Yes ☐ No

Telephone No.: _____

Fax No.: _____

Type of practice: ☐ Sole Proprietor ☐ Partnership ☐ Group Practice ☐ In-House Clinic

Visit Type: ☐ GP ☐ DT ☐ SP ☐ Other: _____

Operating Hours: ☐ 24 hours ☐ Non 24 hours

Lab Tests and Equipment Available:

Lab Tests ☐ Yes ☐ No

ECG ☐ Yes ☐ No

Ultrasound ☐ Yes ☐ No

X-Ray ☐ Yes ☐ No

Nebuliser ☐ Yes ☐ No

Resuscitation Equip. ☐ Yes ☐ No

Others: _____

Referral – Emergency / Trauma Centre and Lab

Specialist Centre / Hospital:

Name 1: _____

Name 2: _____

Name 3: _____

Laboratory referred to:

Name 1: _____

Name 2: _____

Bank Account Details

Name of Bank: _____

Branch: _____

Account No.: _____

Payee Name: _____

Details of Person In-Charge (Payment related matters)

Name: _____

Mobile No: _____

Email Address: _____

Panel Person In-Charge

Name: _____

Mobile No.: _____

Office No.: _____

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PART B – OWNER’S INFORMATION

Name – 1: _____

NRIC No.: _____

Telephone No.: _____

Signature _____

Name – 2: _____

NRIC No.: _____

Telephone No.: _____

Signature _____

PART C – DOCTOR’S INFORMATION

<i>Doctors Name - 1</i>		<i>NRIC No.</i>
<i>Mobile No.</i>	<i>APC No.</i>	<i>Language proficiency</i>
<i>Basic Degree</i> <input type="checkbox"/> MD <input type="checkbox"/> MBBS <input type="checkbox"/> Others: _____		
<i>No. of Year in Practice</i>		<i>Doctor's Signature</i>

<i>Doctors Name - 2</i>		<i>NRIC No.</i>
<i>Mobile No.</i>	<i>APC No.</i>	<i>Language proficiency</i>
<i>Basic Degree</i> <input type="checkbox"/> MD <input type="checkbox"/> MBBS <input type="checkbox"/> Others: _____		
<i>No. of Year in Practice</i>		<i>Doctor's Signature</i>

<i>Doctors Name - 3</i>		<i>NRIC No.</i>
<i>Mobile No.</i>	<i>APC No.</i>	<i>Language proficiency</i>
<i>Basic Degree</i> <input type="checkbox"/> MD <input type="checkbox"/> MBBS <input type="checkbox"/> Others: _____		
<i>No. of Year in Practice</i>		<i>Doctor's Signature</i>

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PART D – CLINIC QUOTATION & OPERATING HOURS

Charges

Description	Charges (RM)
Consultation	
Medication for Common Ailments	
Nebuliser	
Urine Test FEME	
RBS	
X-Ray	
Toilet & Suturing	
ECG	
Ultrasound	

Operating Hours

Day	Time
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	
Public Holiday	

Please Attached Below Documents, Kindly tick

1. Form B or Form F ☐
2. Annual Practising Certificate (APC) ☐
3. Bank Statement (Only Letterhead) ☐

Acknowledged by:

Clinic's Rubber Stamp

Signature & Doctor's Chop