

Application for Registration on the Alliance Midmed HIV Programme

Membership Number

Date

Surname

First Name/s

Is this registration for yourself or a family member?

Myself ☐

Family ☐

Both ☐

Please complete a separate form for each person in your family if applicable

When was HIV Diagnosed?

Are you on ARV's? (Tick block)

Y

N

Please provide us with your contact details in the spaces below so that we can keep in touch

Home Phone

code

Work Phone

code

ext

Shop/Department

Cell Phone (yours)

Cell Phone (alt)

e-mail Address

Postal Address

Where we can send you
information

Doctor's Name & Phone Number

May we contact your doctor directly for information?

Yes ☐

No ☐

Please sign here:

N.B. If you need medication to be registered, we must have your latest CD4 count and Viral Load (Blood test) results to do this. Please ask your doctor to send a copy of your latest prescription and your latest Blood tests to us. Once we have this and register you, you will receive a Care Plan that tells you how many visits and tests will be paid without using your savings.

ALL THE INFORMATION YOU GIVE US WILL BE KEPT STRICTLY CONFIDENTIAL AND WILL NOT BE SHARED WITH YOUR EMPLOYER OR ANYONE OTHER THAN YOUR DOCTORS AND PHARMACY WITHOUT YOUR PERMISSION.

Please return this form to the Alliance Midmed HIV Programme:

By e-mail – auths@alliancemidmed.co.za or

Fax: 086 776 7671

You can also contact one of our Nurses on the following number: 0860 002 101

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