

Application for Registration on the Health Management Programme

Membership Number		Date	
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Surname	
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First Name/s	
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Is this registration for yourself or a family member?	Myself <input type="checkbox"/>	Family <input type="checkbox"/>	Both <input type="checkbox"/>
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Please complete a separate form for each person in your family if applicable

Are you on chronic medication?	Y	N	When were you diagnosed?	
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Please provide us with your contact details in the spaces below so that we can keep in touch

Home Phone	code	
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Work Phone	code		ext
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Shop/Department	
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Cell Phone (yours)		Cell Phone (alt)	
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e-mail Address	
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Postal Address Where we can send you information	
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Doctor's Name & Phone Number	
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May we contact your doctor directly for information?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Are you being treated for any of the following chronic conditions? Please tick whichever apply.

High Blood Pressure <input type="checkbox"/>	Heart Failure <input type="checkbox"/>	Low Thyroid <input type="checkbox"/>	Emphysema <input type="checkbox"/>
High Cholesterol <input type="checkbox"/>	Diabetes on Insulin <input type="checkbox"/>	Asthma <input type="checkbox"/>	Depression <input type="checkbox"/>
Heart Attack/Angina <input type="checkbox"/>	Diabetes on tablets <input type="checkbox"/>	Arthritis <input type="checkbox"/>	Chronic Back/Neck Pain <input type="checkbox"/>
Abnormal Heart Rhythm <input type="checkbox"/>	Chronic Renal Failure <input type="checkbox"/>	Gout <input type="checkbox"/>	Other (please specify below) <input type="checkbox"/>

Please return this form to the Pick n Pay Health Programme:

By e-mail – pnphealth@pha.co.za or by Fax: 031 267 0227

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

0860 767 633 – Option 4 from 08h00 to 16h30 Monday to Friday