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connect@cimas.co.zw
fb.com/cimasmedicalaid
East Block, Borrowdale Office Park
P.O. Box 1243, Harare, Zimbabwe
www.cimas.co.zw

Cimas Care Registration Form

Member Name | Date

Patient's Name | Membership No. | Suffix

National I.D. Number | Date of Birth

Gender | Cell Number

WhatsApp Number | Email

Address

Kindly complete the table below, attach a copy of prescriptions of the Chronic medication being taken and let your doctor verify and sign off this form

Chronic Condition Code	Year of Drug Commencement	Medication and Strength of drugs being taken	Attending Doctor for your condition

Chronic Condition Code

1) Asthma | 2) Psychiatric Conditions | 3) Hypertension | 4) Diabetes | 5) Leprosy | 6) Renal Diseases

7) Epilepsy | 8) HIV | 9) Cardio- Vascular Problems | 10) Cancer, specify type _____

11) Other _____

Patient Consent

*I confirm that the information contained in this registration form is correct. Member's Signature ..... Date .....

Doctor Declaration

*I hereby declare that the information provided is true and correct. Doctor's Signature ..... Date .....

Submit at any Cimas Clinic or send to **cimascare@cimas.co.zw** Alternatively WhatsApp on **0774272744**