Kek Lok Si Charitable Hospital 極樂寺慈善醫院
Managed by Yayasan Kek Lok Si (Co. No. 201601005357 (1176283-H))
T : 04-299 9333 F: 04-828 3223
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REGAIN SIGHT, RETURN TO WORK CAMPAIGN APPLICATION FORM
【视力再现，重返职场】社区医疗计划申请表

Eligibility :

1. Malaysian citizen only.
2. Currently working (self-employed or salaried) .
3. Household income of B40 or per capita household income not more than RM1500.00 per month.
4. Patient without personal insurance coverage or medical benefit from employer.
5. Patient is required to pay RM1000.00 upon admission. The balance will be subsidized by the sponsor.
6. The Hospital reserved the right to grant or reject the application at its sole and absolute discretion.

申请条件 :

1. 马来西亚公民
2. 目前就业中（自雇或受薪）
3. 属于 B40 群体或每月人均家庭收入不超过 RM1500.00
4. 无个人医疗保险或雇主提供医疗福利的患者。
5. 患者入院时须先缴付 RM1000.00, 余额将由赞助方资助。
6. 本院保留全权酌情决定批准或拒绝任何申请的权利。

REFEREE CRITERIA 介绍人条件 :

1. Referee should not be family member of patient 介绍人与患者无亲属关系
2. Referee must be able to verity working status of patient 介绍人必须能够证实患者的工作状况

SUPPORTING DOCUMENTS REQUIRED 所需证明文件 :

1. Photocopy of applicant's identity card 患者身份证复印本
2. Evidence of working status & income (eg: verification letter from employer, pay slip, income tax, EPF statement etc.)
   可证明工作状态与收入的文件（例：雇主的证明信，薪水单，报税单，公积金账目等等）
3. Other supporting documents as required by welfare staff 其他相关文件

PATIENT INFORMATION 患者资料

Name 姓名			
NRIC No. 身份证号码		Gender 性别	☐ Male 男 ☐ Female 女
Race 种族	☐ Chines 华人 ☐ Malay 马来人 ☐ India 印度人 ☐ Other 其他		
Marital Status 婚姻状况	☐ Single 单身 ☐ Married 已婚 ☐ Divorcees 离婚 ☐ Widow/Widower 丧偶		
Address 地址			
Contact No. 联络号码	Home 住家	Mobile 手机	
Employment 工作状况	☐ Salaried: Full-time/Part-time 受薪: 全职/兼职 ☐ Self-employed 自雇		
Employer or business detail 雇主或公司资料	Company name 公司名字		
	Company address 公司地址		
	Position 职位	Company phone no 公司电话号码	

MONTHLY INCOME 每月收入

	Amount	Remarks
Total Household income per month (Patient and spouse) 家庭每月总收入 （患者与配偶）		
Number of children currently not working 目前无工作子女人数		

EMERGENCY CONTACT 紧急联络人资料

Name 姓名		Relationship 关系	
NRIC No. 身份证号码		Age 年龄	Gender 性别
Contact No. (Mobile) 手机电话号码			
Address 地址			

REFEREE'S INFORMATION 介绍人资料

Name 姓名		Relationship 关系	
NRIC No. 身份证号码		Age 年龄	Gender 性别
Contact No. (Mobile) 手机电话号码			
Address 地址			

DECLARATION 声明

Kek Lok Si Charitable Hospital reserves the right to reject applications which do not fulfill the conditions required. The Hospital's decision is final, any appeals will not be accepted.
极乐寺慈善医院保留权利拒绝不符合条件的申请，任何上诉均不受理。

☐ I understand that any false information provided will result in the application being rejected; and in such case Kek Lok Si Charitable Hospital reserves the right to ask for repayment in full for the cost incurred.
本人明白，若被发现提供虚假资料，将导致此申请被拒绝，极乐寺慈善医院有权要求偿还全额的医疗费。

☐ I hereby declare that all particulars and information given above are true and accurate. I shall be fully responsible for all consequences which may arise due to above mentioned.
本人在此声明，以上所提供的资料与信息均属真实正确。若有不正确或属于捏造，本人愿意承担全部责任。

SIGNATURE 签名		NAME 姓名	
NRIC No. 身份证号码		DATE 日期	

FOR KLSCH USE ONLY 仅供极乐寺慈善医院使用	
Received by 收件者	Date 日期
Patient Name 患者姓名	RN No. 注册号码
Consultation Date 诊断日期	OT Date 手术日期
Per Capita Household Income (PCHI) 人均家庭收入 RM Category	
Remarks 备注	
Application Decision 申请结果	☐ Approved 已批准 ☐ Rejected 拒绝
Remarks 备注	
Approved by 审核者 _____ Name 姓名 : Date 日期 :	