



**APPLICATION FORM FOR MEDICAL REPORT / AUTOPSY REPORT
HOSPITAL PUTRAJAYA**



1. Applicant's Details		
Applicant's Name :		
NRIC / Passport No. :	Relationship With Patient/ Deceased :	
Applicant's Address :		
Tel. No. (Home) :	Tel. No. (Mobile) :	
2. Patient's / Deceased Details (Note: Slash if not applicable)		
Patient's / Deceased Name :		
NRIC / Passport No. :	MRN :	
Gender : Male / Female	Age :	Clinic / Ward :
Date of Treatment In Specialist Clinic / Date of Admission :		
Date of Discharge / Date of Death / Date of Autopsy :		
3. Type of Medical Report (Note: Please tick (✓) in the related box)		
i. Normal Medical Report (Citizen: RM40.00 / Non-citizen: RM120.00)		<input type="checkbox"/>
ii. Brief Specialist Medical Report (Citizen:RM80.00 / Non-citizen: RM240.00)		<input type="checkbox"/>
iii. Detail Specialist Medical Report (Citizen: RM200.00 – RM1,000.00 / Non-citizen: RM400.00 – RM2,000.00)		<input type="checkbox"/>
iv. Others, specify :		
Application Purposes: Insurance/ PERKESO/ KWSP/ MySalam/ Others:		
4. Payment Details		
Enclosed herewith is a cheque/ Money Order numbered / cash total RM for medical report payment.		
5. Patient's / Relative Consent (Note: Please tick (✓) in place of marked #)		
I hereby authorize the hospital to issue this Medical Report to the applicant as named above and I also release the hospital from any legal action related to it.		
Signature / Thumbprint :		Signature of Witness :
Patient's / Relative Name :	Witness Name:	
NRIC / Passport No. :	NRIC / Passport No. :	
Date :	Date :	
(#) The original patient's consent letter is attached separately <input type="checkbox"/>		
6. Supporting Document (Note: Please tick (✓) in the related box)		
i. Copy of Patient's / Deceased NRIC / Passport		<input type="checkbox"/>
ii. Copy of Applicant's NRIC / Passport		<input type="checkbox"/>
iii. Copy of Birth Certificate / Death Certificate / Marriage Certificate (If Applicable)		<input type="checkbox"/>
iv. Copy of Payment Receipt		<input type="checkbox"/>
7. Office Use (Note: Please tick (✓) in place of marked #)		
Name of Staff :	Receipt No. :	
Signature :	Date of Receipt :	
(#) Collection Method of Completed Medical Report : Counter <input type="checkbox"/> Postage <input type="checkbox"/>		
Name of Collector :		
Signature :	Date of collection:	