To : CompuMed Services Sdn Bhd

Tel. No. : (6)03- 2089 3826 Fax No. : (6)03 – 2093 8011

Email : cpmd_provider@compumed.com.my

Attn. : Provider Management Department

PANEL OF GP CLINICS
– Reply of Invitation / Application to Join CompuMed as A Panel Clinic

Please tick either one:

( ) **YES!** I would like to be a panel service provider of CompuMed Services Sdn Bhd. I am pleased to forward to you a quotation of our charges. Please forward to me a copy of the Letter of Acceptance of which I shall return to CompuMed after signing. Following that, I look forward to a training session on CompuMed's Outpatient Management System.

( ) **NO.** I am not interested in being a panel service provider of CompuMed Services Sdn Bhd.

Yours sincerely,

Clinic name: _____

Doctor in charge: _____

Staff in charge : _____

Clinic stamp: _____

Date: _____

Please tick where appropriate:-

Do you have internet connection for your PC? ☐ **YES** ☐ **NO**

Do you have a fax machine at your clinic? ☐ **YES** ☐ **NO Fax No.**_____

Where do you station your computer terminal? ☐ Registration Counter

☐ Doctor's Room

Your computer system network? ☐ Stand Alone

☐ Sharing / Networking

Encl/..

CLINIC DETAILS FORM (FS-CPMD73-03)

To : CompuMed Services Sdn Bhd
Tel. No. : (6)03- 2089 3826 Fax No. : (6)03 – 2093 8011
Email : cpmd_provider@compumed.com.my
Attn. : Provider Management Department

Name of Clinic : _____

Party to Be Named : _____
In Panelship Appointment Agreement ***(Clinic Name / Company Name – please provide us Form 49 if registered as "Sdn Bhd")***

Group of (if any) : _____

Address : _____

_____

_____

Clinic Working Hours : _____

Tel No. : _____

Fax No. : _____

Email Add. : _____

For Purpose of Payment

Payee Name : _____

Payee Bank : _____

Payee Bank Account No. : _____

Payee NRIC if Individual: _____

Payee Business Registration No. (BRN) if sole proprietor / partnership: _____

Payee Company No. if Company: _____

Please attach the latest copy of "Perakuan Amalan Tahunan" (Annual Practising Certificate) and photograph of your clinic

Signature : _____

Name : _____

Date : _____

Clinic Stamp :

CLINIC SUMMARY OF QUOTATION/CHARGES (FS-CPMD74-01)

	Type of Treatment	Rate / Charges (RM)	Internal use
1.	Consultation only		
2.	Consultation and Medication (General)		
3.	Consultation + Medication + Injection		
4.	Minor Surgery (procedure) 1. 2. 3. 4. 5.		
5.	X-ray		
6	Simple Investigation :- 1. Blood glucose test 2. Urine test (using test strip) 3. ECG 4. Ultrasound Examination 5. Pap Smear		
7.	Pre-Employment Medical Check-Up (please list out all the tests) 1. 2. 3.		

Prepared by:

Name : ….....

Designation : ….....

Clinic Stamp :