Gilead Medical & Dental Centre

CORPORATE REGISTRATION FORM

INFORMATION OF ORGANISATION

Name of Organisation

Address / Location

Region

Postal Address

Official Email

Landline

Mobile No.

Company Representative

Name

Position

Type of Business

Please attach a copy of certificate of incorporation or registration (whichever is applicable)

Ownership Category *(please tick where applicable)*

☐ Government ☐ NGO ☐ Quasi-Government ☐ Private

Staff Registration Requirements

- List of staff indicating their department / unit and their dependants.
  (Please indicate relationship of dependants to staff, e.g. spouse, child)
- An introductory letter for first attendance for on-site registration.
- Clients shall submit an update of staff information as and when necessary.

Medical Service and Payment Condition

Please see list of our services:

- General Outpatient Services
- Corporate Wellness Services
- Specialist Care: *Physician Specialist, Gynaecology & Obstetrics (Antenatal Care), Cardiology, Men's Clinic, Paediatrics, ENT, Neurosurgery, Clinical Psychology, Orthopaedic, Dermatology, Dietetics*
- General & Specialist Eye Care and Optical Services
- General & Specialist Dental Care
- Orthodontics
- Pharmaceutical Services
- Diagnostics Services - Lab, Ultrascan, ECG, CTG.

A pre-registration deposit is required. This amount shall be paid on registration and shall be used to offset the client`s initial medical bills. See fee below:

- **Corporate Client is GH¢ 1,000.00**

1) A corporate registration fee of **GH¢ 450.00** would be charged upon signing the contract.
   This amount would appear on your bill and would be deducted from the pre-registration deposit paid.
2) The usual credit period for client is thirty (30) days after receipt of medical bill.
3) Gilead Medical & Dental Centre shall be given two weeks prior notice of names withdrawn from the organization's list.
   It shall be the responsibility of the Client to retrieve ID cards from affected staff and their dependants.
4) Where the service received is not covered by the clients` collective agreement, the client shall make an internal arrangement for the recovery of amount paid on behalf of its staffs.

Payment Details

☐ Cash ☐ Cheque No. _____

Amount GH¢ _____

Amount in words _____

Acceptance

We the undersigned having considered the terms and conditions of Gilead Medical & Dental Centre's offer do hereby unreservedly accept. Dated: _____ day of _____ / _____
day *month* *year*

Name _____

Position _____

Signature & Stamp _____