NATIONAL HEALTH FUND

6TH Floor, The Towers, 25 Dominica Drive, Kingston 5
Website: www.nhf.org.jm; Tel.923-6920/923-6926-8 Fax: 923-7159

PHYSICIAN COMMITMENT FORM FOR NHFCARD ONLINE REGISTRATION

1. **Full Name of Physician:** _____
2. **Professional Registration (MCJ) #:** _____
3. **MCJ Practicing Certificate expiration date:** _____
4. **Business Address:** _____

   _____
5. **Contact Details**

   Office #: _____ Cell #: _____

   Email: _____

I _____ **of** _____
(Please print name of Doctor) *(Name of Facility)*

express my interest in participating in the NHFCard Online Registration System and declare:

a) That I acknowledge my professional duty to validate and certify patients' medical information and reports, extends to the NHF online benefits platform;

b) That I will keep and secure my credentials for participating on the NHFCard Application electronic platform under my sole control at all times; these credentials are my username and password and the electronic signature provided by NHF.

c) That the information contained on this form is true, accurate and complete as documented, and I undertake to provide documentary evidence, if required;

_____
Signature

Date _____