Medical Treatment Visa Application Form

Personal Details

Full Name

Date of Birth

Gender

Nationality

Passport Number

Passport Expiry Date

Email Address

Contact Number

Medical Details

Description of Medical Condition

Name of Hospital in Destination Country

Hospital Address

Treating Doctorâ€™s Name

Expected Duration of Treatment

Proposed Treatment Start Date

Proposed Treatment End Date

Accompanying Person (if any)

Full Name

Relationship

Passport Number

Declaration

I declare that the information provided is true and correct. ☐

Signature

Date