



QUIT the SMOKE

Starting date (with/without medication):

Please Complete at home and have it signed by your doctor. Fax back to 061-287 6180 to be registered.

“QUIT the SMOKE” campaign registration form.

Full Names:

Surname:

Nickname:

Date of Birth:

Medical Aid number:

Option:

Telephone number: (w)

Telephone number: (h)

Cellphone number:

Fax number:

E-mail:

How many Cigarettes do you smoke per day? (indicate with an “X”)

Less than 10 per day 20 to 30 per day

10 to 20 per day 30+ per day

How many years do you smoke already?

Are you suffering from any of the following chronic conditions: (indicate with an “X”)

High Cholesterol Diabetes Stroke

High Blood Pressure Cardio Vascular Disease Obesity

I, _____ declare that the above information is correct.

Doctors Signature

Patient’s Signature