FREE MEDICINE PROGRAM CHECKLIST

- ☐ Completed and Signed Registration Form
- ☐ Additional Dependants Form (if any).
- ☐ Evidence confirming annual salary less than $20,000 or Completed and Signed Statutory Declaration.
- ☐ One passport sized color photograph . Please note that this is optional. For FRCA offices, photographs can be taken at the respective offices.

FREE MEDICINE PROGRAM REGISTRATION FORM

1 x passport sized photo duly certified by authorizing officer (optional)

- The Free Medicine Program is to assist individuals who earn less than $20,000 per annum, including dependent children and other dependent persons to access selected medicines from the Government Hospitals/Dispensaries and selected private pharmacies free of charge.
- The registration will determine your eligibility and to enable that you to access the free medicines from the selected Pharmacies near you.
- Provide any other form of photo Identification if you DO NOT have an FNPF/FRCA Joint ID (TIN) Number (e.g. Passport/ Driving License/EVR card).

Use BLOCK LETTERS.

1. Tax Identification Number
2. Social Welfare Number
3. Birth Reg Number
4. National Health Number
5. Applicant's Name
   - 5(a) First Name
   - 5(b) Other Names
   - 5(c) Surname
   - 5(d) Married Name: (Optional and for married woman)
6. Mother's Name:
7. Date of Birth: (dd/mm/yyyy)
8. Gender(√) M ☐ F ☐
9. Marital Status (√) M ☐ S ☐
10. Usual Occupation
11. Home Address:
12. Postal Address:
13. Phone and Other Contact Details

Phone (Home):
Phone (Work):
Mobile:
Email:

14. Dependent Child's/Other Person's Details

14(i) Dependent 1

- 14(a) First Name
- Other Names
- Surname
- 14(b) Date of Birth (dd/mm/yyyy)

14(ii) Dependent 2

- 14(a) First Name
- Other Names
- Surname
- 14(b) Date of Birth (dd/mm/yyyy)

14(iii) Dependent 3

- 14(a) First Name
- Other Names
- Surname
- 14(b) Date of Birth (dd/mm/yyyy)

15. Left thumb print of Applicant

16. Declaration of Application

By virtue of the Statutory Declarations Act (Cap 43), I _____ _____ declare that the information provided in this registration form/*and Additional Dependants Form(s) *is/are accurate and true.

Applicant's Signature: _____ Date: _____

17. Witness' Signature: _____ Date: _____

Name of Witness: _____

Title of Witness: _____

*Please cross out the ones not applicable.

The following are authorized to witness the applicant's signature:

Employer, MOHMS Personnel, Justice of Peace, District Officer, Commissioner for Oaths and FRCA Officer.

FREE MEDICINE PROGRAM REGISTRATION FORM

INSTRUCTIONS FOR COMPLETING THE FORM

General Information

Complete the form in black or blue pen.

PRINT clearly with BLOCK letters and provide relevant information in the boxes provided. If an item is not applicable write "N/A" in the box.

1. Write the valid Joint FNPF/FRCA (TIN) issued by FRCA or FNPF (if any).
2. Write the valid Social Welfare membership number issued by Ministry of Women, Children and Poverty Alleviation (if any).
3. Write the Birth Registration Number given in the box on the upper right hand corner of the Birth Certificate. (Do not complete this Box if you have a foreign birth certificate).
4. Write the valid Health Information Number issued by Ministry of Health and Medical Services. This number should be written on your national health card. This number will be validated against your TIN number by pharmacies when issuing of medicines offered under government's free medicine program. Please note that all individuals with a yearly income of less than $20,000 are eligible for free medicines under this program. (Includes dependent children and other dependent persons)
5. Write the name(s) as shown on your Birth Certificate:
   a. First name.
   b. Other names.
   c. Last Name/Surname.
   d. If you are a married woman and opt to use your marriage name, write the marriage name as on the Marriage Certificate.
6. Write your Mothers's Name as shown on the Birth Certificate.
7. Write your date of birth from the Birth Certificate in the format (dd/mm/yyyy).
8. Tick either (M) for male or (F) for female.
9. Tick either (M) for married or (S) for single.
10. Write your usual and current occupation.
11. Write your current home address.
12. Write your current postal address which you use to collect your mails.
13. Write your Home and Work Phone Contacts together with your mobile contact and email address in the spaces provided.
14. Please fill in the personal details of dependent children or other dependent persons. This includes the full name and Date of Birth. If you wish to include more than 3 dependent children or other persons please fill out the attached Additional Dependants Form. Dependent persons are only limited to individuals under the Mental Health Decree 2010 and who require guardianship or care giving services.
15. Place your Left Thumb print with your Signature in the space provided.
16. Please fill in the Declaration of Application and place your signature with the date in the space provided.*Please cross out the ones not applicable.
17. Declaration of Application should be witnessed by the following personnel: Ministry of Health and Medical Services staff, a General Practitioner, Justice of Peace, District Officer , Commissioner for Oaths or FRCA officer.
18. The witnessing officer to the applicant's left thumb print and signature should put his/her Name, Signature, Title and Date in the spaces provided.

If you DO NOT have any other form of photo Identification or cannot come to any MOHMS office in person, a certified passport size photo with WHITE BACKGROUND is necessary. All passport sized photos must be certified by one of the following persons: Justice of Peace, District Officer, Commissioner for Oaths or FRCA officer. Please note that passport sized photo is optional. For FRCA offices, photographs can be taken at respective offices.

What to do with the completed form?

Take the completed form with the required documents to any MOHMS Facility or FRCA office near you.

The counter officers will be there to assist if you need help in completing this form.

FREE MEDICINE PROGRAM
ADDITIONAL DEPENDANTS FORM

Please use this form to fill in the details of additional dependent children or other dependent persons. Dependent persons are only limited to individuals under the Mental Health Decree 2010 and who require guardianship or care giving services.

Dependent Number is a continuation from the Free Medicine Program Registration Form. Should there be additional dependents, please fill in another form.

Dependent Number

Dependent Child's/Other Person's Name

First Name

Other Names

Surname

Date of Birth: (dd/mm/yyyy)

Dependent Number

Dependent Child's/Other Person's Name

First Name

Other Names

Surname

Date of Birth: (dd/mm/yyyy)

Dependent Number

Dependent Child's/Other Person's Name

First Name

Other Names

Surname

Date of Birth: (dd/mm/yyyy)

Dependent Number

Dependent Child's/Other Person's Name

First Name

Other Names

Surname

Date of Birth: (dd/mm/yyyy)

STATUTORY DECLARATION

I _____

of _____

solemnly and sincerely declare that I have an annual income of less than $20,000.

And I make this solem declaration believing the same to be true and by virtue of the Statutory Declarations Act (Cap 43).

Declared at _____ }
this _____ day of }
_____ }
before me and I certify that the declaration was read }
over in the _____ } _____
_____ language }
to the declarant who appeared fully to understand }
the meaning thereof. }
}
_____ }
(Office held or Nature of Appointment)

EXPLANATORY NOTE

A Statutory Declaration made in Fiji for use in Fiji shall be in the form prescribed in the Schedule to the Statutory Declaration Act and shall be made before :-

(a) The Chief Register, Deputy or Assistant Registrar of the Supreme Court :
(b) a magistrate :
(c) the Registrar-General or any Assistant Registrar-General :
(d) a notary public or Commissioner for Oaths :
(e) a Registrar of Magistrates' Courts :
(f) a barrister and solicitor
(g) a justice of peace
(h) a district officer; or
(i) any fit and proper person appointed by Minister charged with responsibility for the Ordinance