THE FEDERAL POLYTECHNIC, ILARO
MEDICAL CENTRE

AFFIX A PASSPORT

MEDICAL REGISTRATION FORM

PERSONAL INFORMATION

CLINIC NO: _____ **LAB NO: _____**

Name: _____
Surname ***First Name*** ***Other Name***

Age: _____ **Sex: _____**

Ilaro Address: _____

Phone Number: _____

Department: _____

Matric Number: _____

Blood Group: _____ **Genotype: _____**

State of Origin: _____

NEXT OF KIN DETAILS

Name: _____

Phone Number: _____

Address: _____

Relationship: _____
Mother/Father

_____
DATE