

No:

SULTAN AHMAD SHAH MEDICAL CENTRE @IIUM
SLIP PEMBAYARAN IMEJ CD
(CD IMAGES PAYMENT SLIP)


Tarikh (Date): _____

Masa (Time): _____

Nama (Name)	:	
RN & No Kad Pengenalan (RN & NRIC)	:	
Jabatan (Department)	:	
Tarikh Rawatan (Treatment date)	:	
Jenis Imej (Type of image)	:	
Bayaran (Payment)	:	
Nama Doktor (Doctor Name)	:	

UNTUK KEGUNAAN PEJABAT
(FOR OFFICE USE ONLY)

JABATAN MAKLUMAT PESAKIT (MEDICAL RECORDS DEPARTMENT)	JABATAN KEWANGAN (FINANCE DEPARTMENT)
NAMA: (Name)	NAMA: (Name)
Tandatangan & Cop: (Signature & Stamp)	Tandatangan & Cop: (Signature & Stamp)
Tarikh: (Date)	Tarikh: (Date)



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