



APPLICATION FORM FOR PATIENT NAME CORRECTION

Date

Patient's Name *

Father's Name

Gender

Age

SMBBIT Medical Record No.*

Patient's CNIC No.*

Name & Relationship with Patient

Requester Contact No.

Authorized Signature (Other than Patient)

Requester CNIC No.

Cause of incorrect Information feed in HMIS.

Please Note:

- A copy of National Identity Card of both the Patient & attendant must be submitted with Application Form.
- Copy of Emergency Slip must be attached.

Submit