

**Application for Registration on the Fortitude Programme**

Membership Number  Date

Surname

First Name/s

Is this registration for yourself or a family member? Myself  Family  Both

**Please complete a separate form for each person in your family if applicable**

Are you on chronic medication? Y  N  When were you diagnosed?

**Please provide us with your contact details in the spaces below so that we can keep in touch**

Home Phone  code

Work Phone  code  ext

Department

Cell Phone (yours)  Cell Phone (alt)

e-mail Address

Postal Address  
Where we can send you information

Doctor's Name & Phone Number

What is your current weight and height? Weight  Height

**Are you being treated for any of the following chronic conditions? Please tick whichever apply.**

High Blood Pressure <input type="checkbox"/>	Heart Failure <input type="checkbox"/>	Low Thyroid <input type="checkbox"/>	Emphysema <input type="checkbox"/>
High Cholesterol <input type="checkbox"/>	Diabetes on Insulin <input type="checkbox"/>	Asthma <input type="checkbox"/>	Depression <input type="checkbox"/>
Heart Attack/Angina <input type="checkbox"/>	Diabetes on tablets <input type="checkbox"/>	Arthritis <input type="checkbox"/>	Chronic Back/Neck Pain <input type="checkbox"/>
Abnormal Heart Rhythm <input type="checkbox"/>	Chronic Renal Failure <input type="checkbox"/>	Gout <input type="checkbox"/>	Other (please specify below) <input type="checkbox"/>

**Please return this form to Your Dedicated Professional Nurse or:**

**By e-mail to: [fortitude@pha.co.za](mailto:fortitude@pha.co.za) or**

**By Fax to: 0866 034 606**

