



APPLICATION FORM FOR CFAI MEDICAL IDENTIFICATION CARD

Fill in the following fields with the information you wish to have included on the card. Please use block capitals.

Name: _____

Address: _____

Telephone: Home _____

Work _____

Mobile _____

Date of Birth (DOB): _____

Doctor: _____

Doctor Telephone: _____

Hospital: _____

Hospital Telephone: _____

Hospital number: _____

Other conditions (other than CF e.g. diabetes): _____

Allergies: _____

Medications: _____

In case of emergency please contact: _____

Telephone: _____

*** Please ensure you enclosed a PASSPORT PHOTOGRAPH of yourself and have SIGNED THE ID CARD.**

Return FORM & CARD to:
Medical Identification Card
CF House
24 Lower Rathmines Road
Rathmines
Dublin 6