CMR MYCARD - BUSINESS ENROLMENT FORM

Cape Medical Response CC. Reg No CK 2001/013020/23.
106 Kommetjie Rd, Fish Hoek, Cape Town 7975. P.O. Box 37758, Valyland, Cape Town, 7978.
Tel: 021 782-0606. E-Mail: ronel@cmr-med.co.za. Medical Emergencies: 082 782-4444 or 021 782-4444.

CAPE MEDICAL RESPONSE

(Effective 5 August 2026)

DETAILS OF ESTABLISHMENT (PROGRAMME PARTNER) *(Block capitals please)*

Name: _____

Physical address: _____

Suburb: _____ Code: _____

Telephone: _____ Fax: _____

Website: _____

Email address: _____

Description of business/attraction: _____

_____

Business Days and Hours: _____

DETAILS OF RESPONSIBLE PERSON

Title: _____ Surname: _____

First Name/s: _____

Position: _____

Telephone: Work: _____ Cell: _____

Email address: _____

Details of Offer/s to CMR My Card holders and conditions or restrictions

1. _____
2. _____
3. _____
4. _____

(These Offer/s may be changed periodically by completing the "Change to the CMR My Card Offer/s Form" and returning it to CMR)

Please clearly indicate particular offer/s, and any day/time restrictions.

I/we confirm that I/we are authorized to agree to participate in the CMR My Card programme as a Programme Partner and to honour the offer/s to CMR My Card holders as detailed above. By my/our signature hereto, I/we confirm that I/we have read and fully understood the Terms and Conditions of joining the CMR My Card Programme as a Programme Partner. I/we understand that CMR My Card may/will promote our offer/s as CMR/CMR My Card see fit, and CMR and CMR My Card cannot be held responsible for any errors or emissions in this regard. I/we understand that we may terminate the offer/s by giving CMR/CMR My Card one month's calendar notice, and CMR/CMR My Card may withdraw the Offer/s at any time in their sole discretion.

Signature (duly authorised): _____ | For CMR: _____

Name: _____ Date: _____ | Name: _____

FOR OFFICE USE: Notes: _____

_____

_____

_____

Loaded on website: Initial: _____ Date: _____ Emailed to members: Initial: _____ Date: _____