



Date: / /

**CLINIC REGISTRATION FORM**  
**For On-Line Medical Access Program**  
Provided for KSA Visa System Accredited with the Saudi Embassy

COMPLETE CLINIC NAME

SHORT NAME

CLINIC CODE NUMBER

COMPLETE ADDRESS

CONTACT NUMBERS

E-MAIL ADDRESS

AUTHORIZED NAME

"main or head"

SEAL

SIGNATURE

***PLEASE fill up the information clearly.***