HEALTH SCREENING FORM 2025/26

ADMINISTRATORS OFFICE
GABORONE

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bpomas
BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

*This form must be filled in immediately following completion of health screening by members aged 40 years and above or those only eligible for Cervical Cancer Screening and HIV/AIDS Screening. Relevant health screening must be conducted during Annual Health Check for eligible members. Once fully completed, the form must be emailed by the General Medical Practitioner (GP) to **healthscreening@bpomas.co.bw**

Note: Sections 1 - 3 to be completed by the Principal Member and / or the Patient

SECTION 1: DETAILS OF THE PRINCIPAL MEMBER

First Name | Surname

Identity Number | Membership Number

Telephone Number | Mobile Number

Postal Address

Residential Address

Email Address

SECTION 2: DETAILS OF THE PATIENT (If different from the Principal Member)

First Name | Surname

Identity Number | Membership Number

Telephone Number | Mobile Number

Postal Address

Residential Address

Email Address

SECTION 3: BPOMAS DATA PROTECTION AND PRIVACY STATEMENT

This Privacy Statement explains how BPOMAS collects, uses, stores, and protects Personal Information, including Sensitive Health Information, in the course of delivering medical aid services to our members. We are committed to protecting your privacy and ensuring compliance with the Data Protection Act (DPA) and other applicable international data protection laws.

1.1. What Personal Information We Collect

We may collect the following types of Personal and Sensitive Information:

- Full name, date of birth, identification numbers
- Contact details (e.g., address, phone, email)
- Membership and account details
- Medical history, treatment records, and diagnostic reports
- Claims and billing information

1.2. How We Use Your Data

We use your data to:

- Provide and manage medical aid services
- Process claims and benefits
- Coordinate care with healthcare providers
- Communicate with you about your membership or benefits
- Fulfil our legal, financial, and regulatory obligations
- Research and statistical purposes
- Transact with suppliers, business partners, and healthcare service providers
- General administration purposes pertaining to my membership

1.3. Legal Basis for Processing

We process your data under:

- Contractual obligation
- Consent to the processing of your Personal Information
- Performance of a legal obligation
- Protection of our and your legitimate or vital interests

1.4. Data Sharing

We may share your data with:

- Medical professionals and healthcare providers
- Third-party administrators or service providers under contract
- Regulators, auditors, or insurers where legally required
- All third parties are subject to confidentiality and data protection agreements.

1.5. Data Retention

We retain personal data only as long as necessary to:

- Fulfil our contractual and legal obligations
- Meet medical, billing, or reporting requirements
- Resolve disputes and enforce rights
- Retention periods are set based on legal, regulatory, and operational needs.

1.6. Data Security

We implement appropriate technical and organizational measures to protect your data, including:

- Encryption and secure data storage
- Role-based access controls
- Regular security audits and staff training

1.7. Your Rights

You have the right to:

- Access and obtain a copy of your information
- Correct inaccurate or incomplete information
- Object to processing under certain conditions
- Request erasure or restriction of your information
- Lodge a complaint with the Information and Data Protection Commission
- To exercise any of these rights, contact us at dataprotection@bpomas.co.bw.

1.8. Transfers of Personal Data outside of Botswana

Personal Information that we collect from you may be transferred to, and stored at, a destination outside of Botswana. It may also be processed by staff operating outside Botswana who are employees of our third-party providers. Where we transfer your Personal Information outside the jurisdiction, we will endeavour to ensure that there are adequate safeguards in place, in accordance with the DPA. By submitting your Personal Information, and in providing any Personal Information to us, you agree to this transfer, storing or processing.

SECTION 4: ACKNOWLEDGEMENT AND CONSENT BY MEMBER

I acknowledge that;

I have read and understood the provisions of BPOMAS's Data Protection and Privacy Statement, thereby fully appreciating the manner in which BPOMAS may process my Personal Information and for which purpose(s) BPOMAS may process such Personal Information.

As a member I may supply BPOMAS with my next of kin's and dependents personal information – this will only be processed where required to protect legitimate interests or for BPOMAS legitimate business interests/contractual obligations. It is my responsibility to ensure that my next of kin and/or dependents do not object to the provision and or processing of their Personal Information.

In accordance with the provisions of the DPA, I have been provided with adequate notification of the processing of my Personal Information by BPOMAS, the scope and purpose(s) for such processing, as well as my rights to object to such processing should I elect to do so, and to request for access/destruction of my Personal Information that is held by BPOMAS.

In light of the above Acknowledgements and Privacy Statement, and in accordance with the requirements set forth in the Data Protection Act, I hereby provide my specific and informed consent to BPOMAS for the processing of my Personal Information and that of my dependents for any purpose(s) legitimately connected or related to my application for membership.

Sign: _____ Date: _____

Note: Sections 4 – 6 to be filled in by the attending General Medical Practitioner (GP)

SECTION 5: DETAILS OF THE GENERAL MEDICAL PRACTITIONER

First Name | Surname

Practice Name | Practice Number

Telephone Number: | Mobile Number

Postal Address

Physical Address

Email Address

SECTION 6: MEMBER / PATIENT ANNUAL HEALTH CHECK DATES

Date of First Consultation | D | D | M | M | Y | Y | Y | Y |

Date of Follow Up Consultation | D | D | M | M | Y | Y | Y | Y |

SECTION 7: MEMBER / PATIENT CHRONIC DISEASE SCREENING

Physical Assessment

Age ____ Gender ____ Height ____ Weight ____ BMI ____

Waist Circumference ____ Blood Pressure ____ Pulse ____ Smoker: Yes ____ No ____

Point of Care Test

Total Cholesterol ____ Random Blood Glucose ____

General Chronic Disease Screening

Diabetes, Hyperlipidaemia & Cardiovascular Disease Screening (40+ years, once a year) Yes ____ No ____

HIV/AIDS Screening (16+ years, once a year) Yes ____ No ____

Female Chronic Disease Screening

Breast Cancer Screening (40-70 years, every 2 years) Yes ____ No ____

Cervical Cancer Screening (22-55 years, every 2 years) Yes ____ No ____

Male Chronic Disease Screening

Prostate Cancer Screening (40+ years, every 2 years) Yes ____ No ____

Reference Radiology Service Provider (where applicable): _____

Reference Laboratory Service Provider: _____

Is the patient enrolled into the BPOMAS Chronic Disease Management Program? Yes ____ No ____

Overall wellness status of the patient:

_____

_____

_____

Additional information:

_____

_____

_____

GP Signature: _____ Date: _____

Clinic Stamp: