

طلب مشاركة

Participation Request

برنامج المول الصحي

Healthy Mall Program



وزارة الصحة
Ministry of Health

Date: -----

Name of the Mall: -----

Name of the Managing Director: -----

Contact number of the Managing Director: -----

Name of the in-charge of the project from the mall: -----

Contact number of the in-charge: -----

Email of the in-charge: -----

Participation type:

Silver Level

Gold Level

Managing Director of the mall

By signing this form, I hereby acknowledge that I understand the program and its requirements and will cooperate with the Ministry of Health to implement the program in the mall within one year from signing this participation form.