GUHealth

Provider registration and additional practice application

Please print in black ink, using capital letters and mark check boxes with an X.

GU Health Provider No. (if known)

Commencement date D D M M Y Y Y Y

With this form you can apply to become a GU Health registered provider or register details for additional practice/s.

Please complete the information requested below and send your completed form by:

- Scan and email to corporate@guhealth.com.au; **or**
- FreePost to GU Health, Reply Paid 2988, Melbourne Vic 8060 (no stamp required)

For assistance or more information call your GU Health Member Relations Team on **1800 249 966** between 8.30am and 5pm (AEST) Monday to Friday **or** email **corporate@guhealth.com.au**

Section 1: Provider details (must be completed)

Title

Surname

Given name

Business name

Practice address

State

Postcode

Postal address (if different from practice address)

State

Postcode

Telephone number

Mobile number

Email address

Section 2: Additional practice details (Photocopy this section if you have more than three clinic addresses)

1: Business name

Practice address

State

Postcode

Telephone number

Email address

2: Business name

Practice address

State

Postcode

Telephone number

Email address

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Section 3: Provider information (must be completed)

Modalities practised

1.

2.

3.

Professional qualifications

Current first aid certificate details

Association registration details

Association registration number

Liability insurance details

Australian Business Number (ABN)

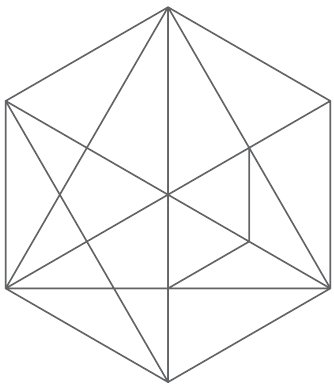
Section 4: Declaration (must be signed)

I declare and acknowledge that all the information I have provided in this form is correct. I understand that there are penalties for giving false or misleading information. Should any of the above details change, I'll notify GU Health immediately.

Provider's signature

Date signed

D D M M Y Y Y Y



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