GUHealth

Provider registration and additional practice application

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

GU Health Provider No. (if known) Commencement date (DD/MM/YYYY)

Provider details (must be completed)

Title Your full name

Business name

Practice address

Suburb State Postcode

Postal address (if different from practice address)

Suburb State Postcode

Contact phone Email

Additional practice details

1. Business name

Practice address

Suburb State Postcode

Contact phone Email

Additional practice details (continued)

2. Business name

Practice address

Suburb State Postcode

Contact phone Email

Provider information (must be completed)

Modalities practiced

1.

2.

3.

Professional qualifications

Current first aid certificate details

Association registration details (including registration number)

Liability insurance details

Australian Business Number (ABN)

Declaration

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

Need help?

Visit **guhealth.com.au/for-providers**

Please return your completed form via

Email: **providers@guhealth.com.au**

Privacy

For information on how we manage your personal information, including how you can seek access to or correct your personal information, please refer to our privacy policy at **guhealth.com.au/privacy-policy**