

## 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

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](mailto: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](mailto:corporate@guhealth.com.au)

### Section 1: Provider details (must be completed)

Title	Surname	
<input type="text"/>	<input type="text"/>	
Given name		
<input type="text"/>		
Business name		
<input type="text"/>		
Practice address		
<input type="text"/>		
		State
		<input type="text"/>
		Postcode
		<input type="text"/>
Postal address (if different from practice address)		
<input type="text"/>		
		State
		<input type="text"/>
		Postcode
		<input type="text"/>
Telephone number	Mobile number	
<input type="text"/>	<input type="text"/>	
Email address		
<input type="text"/>		

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

<b>1: Business name</b>		
<input type="text"/>		
Practice address		
<input type="text"/>		
		State
		<input type="text"/>
		Postcode
		<input type="text"/>
Telephone number	Email address	
<input type="text"/>	<input type="text"/>	
<b>2: Business name</b>		
<input type="text"/>		
Practice address		
<input type="text"/>		
		State
		<input type="text"/>
		Postcode
		<input type="text"/>
Telephone number	Email address	
<input type="text"/>	<input type="text"/>	

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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)

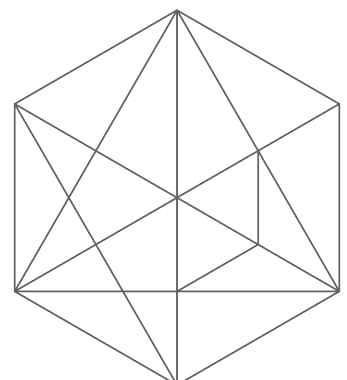
**Section 4: Declaration** (must be signed)

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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