GUHealth™
Your ultimate solution

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Provider Registration Application

GU Health Provider No.:

Commencement date: D D M M Y Y Y Y

With this form you can apply to become a GU Health registered provider. Send your completed form by:

- FreePost to GU Health, Reply Paid 2988, Melbourne VIC 8060 (no stamp required); or
- FreeFax to 1800 656 778.

For assistance or more information call your GU Health Member Relations Team on 1800 249 966 8.30am – 5.00pm (EST) Monday to Friday, or email corporate@guhealth.com.au

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

Section 1: Your details

Title: Surname: Sex: M F

Given name: Date of birth: D D M M Y Y Y Y

Home address:

State: Postcode:

Postal address: (if different from home address)

State: Postcode:

Work telephone number: Home telephone number: Mobile number:

Email address:

Section 2: Practice details

Business name:

Practice address:

State: Postcode:

Phone number: Fax number:

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Section 2: Practice details (if you have more than two clinics please attach a separate sheet with relevant details)

Additional practice address:

State: Postcode:

Phone number: Fax number:

Section 3: Practice details

Modalities practised:

Professional qualifications:

Current first aid certificate details:

Association registration details:

Association registration number:

Liability insurance details:

Australian Business Number (ABN):

Section 4: Declaration

I hereby declare that the above information is true and correct and should any of the above details change, I will notify GU Health immediately.

Policyholder's signature: Date:

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