Registered Provider Application Form

Antenatal Shared Care Program

Personal and professional details:

Surname: ..... Given Name: .....

Name of Practice: ..... Qualifications: .....

Postcode ..... AHPRA Number .....

Telephone: ..... VR: ☐ YES ☐ NO

Practice Fax: ..... RACGP QI&CPD no.: .....

Personal email: ..... HPI-I no: .....

I consent to receiving Practice News Upcoming Education via email (*please tick box*): ☐

Required documentation attached?

Professional Indemnity Insurance Certificate ☐

Declaration:

I agree to adhere to the Antenatal Shared Care Protocol and Program Guidelines, contained within this document.

Signature: …… **Date:** ……

Please post with evidence of qualifications and professional indemnity insurance to:

Attention: Antenatal Shared Care Program
WHL, Blg BR Level 1, Suite 1
Locked Bag 1797,
PENRITH NSW 2751

Or scan & email to: ansc@nbmphn.com.au