



Clinic details:

Name: _____

Address: _____

Phone: _____ *Mobile number: _____ IP Address: _____ . _____ . _____ . _____

unsure of the IP address, please go to www.whatismyip.com

*Email address: _____

***MANDATORY FIELDS - required for account management**

Practitioners' Details:

Please list the full names and provider numbers of all practitioners to whose patient's results staff access is required.

Title _____ Name _____ Provider number _____

Title _____ Name _____ Provider number _____

Title _____ Name _____ Provider number _____

Title _____ Name _____ Provider number _____

Title _____ Name _____ Provider number _____

Staff Details:

Please list the staff who will be the contacts for the account. A single, generic account will be issued for use by multiple staff in the clinic.

Primary Contact _____ Mother's maiden name: _____ Date of birth _____

Additional Contact _____ Mother's maiden name: _____ Date of birth _____

Additional Contact _____ Mother's maiden name: _____ Date of birth _____

Declaration:

We accept full responsibility for maintaining the confidentiality of the information supplied to us by Sullivan Nicolaides Pathology and acknowledge that this information will be used only for ongoing patient care.

Clinic Principal Doctor Authorisation

Clinic Manager

Name _____

Name _____

Signature _____

Signature _____

Date _____

Date _____

Please complete the form and return to:
Doctor IT Services
Sullivan Nicolaides Pathology
A: PO Box 2014, Fortitude Valley Qld 4006
P: +61 7 3377 8611
F: +61 7 3318 7404

Upon receipt of this form you will be allocated a unique username and password to access the service. An email containing your username will be sent to you from sonicdx@snp.com.au and an SMS will be sent with your password.

For security reasons we are unable to send the password via email.

Office use only:

Username: _____
SNP Code: _____

NOVEMBER 2016