



Clinic/Ward Application

CLINIC/WARD CONTACT DETAILS

Clinic/Ward Address
Phone No:

PRACTITIONERS/STAFF INFORMATION

(Please list full details of each person requiring access to the Practitioner's referrals and copies and the full details of the Practitioners involved)

Practitioners details

(please print)

Title	Name	Provider Number	DOB

Details of staff requiring access to referrals

In the event you forget your username and/or password, we need to verify your identity. Please enter your date of birth in the DOB field.

(please print)

Name	Position	DOB

DECLARATION

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

We agree to notify Sullivan Nicolaides Pathology on leaving this Practice, so that this Webster Account can be deactivated if not used within 3 months.

Clinic/Ward Principal Doctor Authorisation.

(please print)

Name	Signature	Date

Clinic/Ward Manager

(please print)

Name	Position	Signature	Date