## www.mediclaim.ca

## **Practitioner Membership Registration Form**

Last Name		First Nam	e
Address			
City		Postal (	Code
Office Telephone		Home / Cell P	Phone
E-mail Address			
<><><><><><>Contact Person: Same		><><><><	><><><><>
Name		Phoi	ne
Email Address			
<><><>	<><><	><><><>	><><>
How did you hear abo	ut us? / F	Referred by	
Nature Of Practice / Sp	ecialty		·
MSP Practitioner Num	ber	MSP Paye	e Number
Visa / MasterCard #			
Expiry Date/	Name o	on Card	
amount on a monthly basis. It is	my responsi	bility to keep my credit card in	ge my credit card the agreed upon formation current and up-to-date. 80 days written notice to MediClaim.
		laim's Terms of Service in delaying your registration)	
Signature			
Date			
	ept strictl www.	nent to MediClaim at y confidential. Please se mediclaim.ca/policy.jsp 73-0046 ext. 1 or email u	e our privacy policy at
For Office Use Only			
Doc Key	CL	FS	CB
Opted Status: In □ Out □			