Centre for Eye Health

# Registered Practitioner Change of Details form

**Fax to 02 8115 0799 or Email to enquiries@cfeh.com.au**

## PRACTITIONER DETAILS

**Profession:** _____ **Medicare Provider *:** _____

**Title:** _____ **First name:** _____ **Surname:** _____

**Mobile #:** _____

## ADD AN ADDITIONAL PRACTICE NOW MY PRIMARY PRACTICE Y/N

**Practice Name:** _____ **Medicare Provider *:** _____

**Mail Address:** _____

**Suburb:** _____ **State:** _____ **Postcode:** _____

**Email:** _____ **Practice Phone:** _____

## REMOVE MY LISTING FROM A PRACTICE

**Practice Name**: _____

**Medicare Provider Number***: _____

## UPDATE MY DETAILS

*(For Correspondence Other Than Reports)*

Yes I would like to receive updates via ☐Email or ☐Post ☐No I do not want to receive updates

**Email:** _____

**Postal Address:** _____

## AGREEMENT

I confirm that the information I have provided above is correct.

Signature: _____ Date: ☐☐/☐☐/☐☐☐☐

*For use by CFEH for internal unique identification purposes only.

**CFEH Office Use Only**

Date received: _____ VIP ❑ DR ❑ PACK ❑ SCAN ❑ Initial Registration :_____