



'CBHS' is:
 CBHS Health Fund Limited and CBHS Corporate Health Pty Ltd
 ABN 87 087 648 717 ABN 85 609 896

Provider recognition application

Please complete and return to:
By post:
 CBHS Health Fund Limited
 Provider Relations
 Locked Bag 5014
 Parramatta NSW 2124
Fax: 02 9843 7677
Member Care Centre: 1300 654 123

Personal details

- Title** Mr Mrs Ms Miss Other
- Surname**
- Given name(s)**

Practice details

- Business name**
- Postal address**

 State Postcode
- Practice address**

 State Postcode
 If multiple practice addresses, please attach a separate sheet.
- Phone number** ()
- Fax number** ()
- Mobile**
- Email**

Modalities practiced

- Please select modalities practiced**

Acupuncture <input type="checkbox"/>	Naturopathy <input type="checkbox"/>
Audiometry/Audiology <input type="checkbox"/>	Nutrition <input type="checkbox"/>
Dietician <input type="checkbox"/>	Orthotist <input type="checkbox"/>
Herbal Medicine <input type="checkbox"/>	Physiology <input type="checkbox"/>
Homeopathy <input type="checkbox"/>	Psychology/Psychotherapy <input type="checkbox"/>
Hypnotherapy <input type="checkbox"/>	Speech Therapy <input type="checkbox"/>
Massage <input type="checkbox"/>	Other (please specify) <input type="checkbox"/>

- Are you currently registered with:**

Medicare Australia? No Yes ► Provider number

Medibank Private? No Yes ► Provider number

- Name of Association or Board you are currently registered with**
 Registration/Membership number

Professional Qualifications/Experience

- Qualifications attained (year)**
- Institution**
- Total length of study (hours)**
- Have you been practicing continuously since gaining the qualifications?**
 Yes No
NOTE: Copies of documents must be provided with this form for each modality practiced.

Professional Indemnity Insurance details

- Insurer**
- Commencement date** / /
- Renewal date** / /
NOTE: Copies of documents must be provided with this form.

Senior First Aid Certificate details

- Institution**
- Commencement date** / /
- Renewal date** / /
NOTE: Copies of documents must be provided with this form.

Other details

- Are you the subject of any unresolved complaint to, or complaint or investigation finding by a professional association or registration/recognition/professional services review body?**
 Yes ► Please give details
 No
- Have you ever been the subject of an adverse finding by such an association or body?**
 Yes ► Please give details
 No

Declaration

I hereby declare that the above information is true and correct. Should any of the above details change, I will notify CBHS in writing within seven days of the change.

Signature