e-Doc
Service Provider Information

METHEALTH NAMIBIA
ADMINISTRATORS

Application Form For e-DOC

Account Details (To be completed in Block Letters)

Practice Number:	
Practice Name:	
Postal Address:	
Physical Practice Address:	
E-mail Address:	
Surname:	
First Names:	
Title:	
Work Phone: ( )	Fax: ( )
Cell Number:	
Preferred date of installation:	
FOR OFFICE USE ONLY	
Submitted by:	
Login:	
Password:	
Comments:	

Minimum System Requirements

- **Windows 95/98/2000/XP**
- **Internet Explorer Version 4.0/Netscape**
- **Modem (28800 Kbps)**

Signature: ______________________ Date: ____ /____ /____

Send to: **Information Systems Department**
METHEALTH NAMIBIA ADMINISTRATORS
FAX: **(+264 61) 287 6024**
TEL: **(+264 61) 287 6000**
E-mail: **isdata1@methealth.com.na**

INDEMNITY CLAUSE

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