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

1. **Title** Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐
2. **Surname**
3. **Given name(s)**

Practice details

4. **Business name**
5. **Postal address**
   State Postcode
6. **Practice address**
   State Postcode
   If multiple practice addresses, please attach a separate sheet.
7. **Phone number** ( )
8. **Fax number** ( )
9. **Mobile**
10. **Email**

Modalities practiced

11. **Please select modalities practiced**

Acupuncture ☐	Naturopathy ☐
Audiometry/Audiology ☐	Nutrition ☐
Dietician ☐	Orthotist ☐
Herbal Medicine ☐	Physiology ☐
Homeopathy ☐	Psychology/Psychotherapy ☐
Hypnotherapy ☐	Speech Therapy ☐
Massage ☐	Other (please specify) ☐

12. **Are you currently registered with:**
    Medicare Australia? No ☐ Yes ☐ ▶ Provider number
    Medibank Private? No ☐ Yes ☐ ▶ Provider number
13. **Name of Association or Board you are currently registered with**
    Registration/Membership number

Professional Qualifications/Experience

14. **Qualifications attained (year)**
15. **Institution**
16. **Total length of study (hours)**
17. **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

18. **Insurer**
19. **Commencement date** / /
20. **Renewal date** / /

NOTE: Copies of documents must be provided with this form.

Senior First Aid Certificate details

21. **Institution**
22. **Commencement date** / /
23. **Renewal date** / /

NOTE: Copies of documents must be provided with this form.

Other details

24. **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 ☐
25. **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 / /