BreastScreen GP Electronic Messaging Registration Form

Practice Name:	
Phone:	
Postal address	
Street address:	
Secure Messaging Providers:	☐ Medical Objects ☐ Healthlink
Practice manager name:	
Practice manager phone:	
Practice manager email:	

I confirm that all GP's working in the practice will be moving to electronic messaging.

Name: _____

Signature: _____

Date: _____

List all providers at your practice:

Provider Medicare Number	Provider First Name	Provider Surname