

## Provider Request for Web Based Registration

Only return if you wish to request Web Based Registration  
(Please type or print clearly)

### Individual Practitioner

Please list all staff requesting access (each staff member must sign confidentiality agreements – please attach all originals to this request)

Provider Name: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please list all staff requesting access (please type or print clearly):

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Facility

Please list all staff requesting access (each staff member must sign confidentiality agreements – please attach all originals to this request)

Facility Name: \_\_\_\_\_  
 Coordinating Supervisor: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please list all staff requesting access (please type or print clearly):

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_