

Healthcare Professionals Initial Registration

Please complete the following form



Full Name:

Correspondence Address:

Contact Number:

Email Address:

GMC No.:

HCPC No.:

Initial consultation/session fee:

Follow up consultation/session fee:

Clinical Specialty:

Sub –Specialties:

Medical Secretary Name:

Secretary Phone and Email:

Hospitals where You have admitting rights/practicing privileges:

Clinic or Availability Times:

Please confirm You agree to bill within our Fee Schedule, also found on the General & Medical Website.
Please provide details of procedure and fees You may perform that will fall outside of this on a separate sheet.

General & Medical currently make payment by cheque. Other payment methods may be subject to an administration fee. Please provide remittance address and to whom payable: