



PRACTITIONER APPLICATION FORM

PRACTITIONER DETAILS

NAME	
DEGREE(s)	
LICENSE NUMBER	
OFFICE/CLINIC NAME	
PHONE NUMBER	
FAX NUMBER	
E-MAIL ADDRESS	

CLINIC INFORMATION

OFFICE CONTACT NAME	
E-MAIL ADDRESS	
SHIPPING ADDRESS	
BILLING ADDRESS (if different from above)	

BILLING METHOD PREFERENCE

Order and Pay on-line: Y / N

Credit Card on file: VISA / MC Card # _____

Exp.Date _____ CVV# _____

SIGNATURE _____

Would you like to be listed as referring doctor on our website? Y/N

Would you like to receive any promotional marketing material? Y/N

Please fill out and email back to sales@sibocanada.com or fax 604-514-8557

