



PRACTITIONER APPLICATION FORM
LACTOSE, SUCROSE, FRUCTOSE BREATH TEST KIT

PRACTITIONER NAME	
DEGREE	
LICENSE NAME	
OFFICE/CLINIC NAME	
PHONE NUMBER	
FAX NUMBER	
EMAIL	

PLEASE CIRCLE TYPE LACTOSE SUCROSE FRUCTOSE

CLINIC INFORMATION

OFFICE CONTACT NAME	
EMAIL	
SHIPPING ADDRESS	
BILLING ADDRESS *If different from above	

BILLING METHOD PREFERENCE

Order and pay online: Yes / No

Credit card on file: Visa/MasterCard #: _____

Expiry: _____ CVV: _____

Signature: _____

Would you like to be listed as a Referring Practitioner on our website? Yes / No

Would you like to receive Promotional Marketing Material? Yes / No

Please fill out and email back to sales@sibocanada.com

Or fax to (604) 514-8557