PRACTITIONER APPLICATION FORM

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

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
sibocanada@gmail.com Or fax to (604) 514-8557