HPS Pharmacies
JOONDALUP HOSPITAL PHARMACY

CLIENT LOGIN APPLICATION FORM

THIS FORM WILL NOT BE ACCEPTED WITHOUT A SIGNATURE

PLEASE FAX FORM TO 08 9400 9901.

YOUR RESPONSE WILL BE FORWARDED AFTER VERIFICATION OF YOUR APPLICATION IN APPROX 2-3 DAYS

DOCTOR (Please Print)			
SURNAME:		FIRST NAME:	
PROVIDER NUMBER:			
PRACTICE NAME:			
ADDRESS:			
PHONE:		FAX:	
EMAIL:	(This is where HPS will forward your username and initial password to. Please ensure its privacy before providing.)		

By signing this form I agree to access this information strictly for professional reasons with the knowledge that it is confidential information and is covered by the laws of patient confidentiality.

SIGNATURE: ______________________ DATE: ____________

OFFICE USE ONLY:			
ACCOUNT VERIFIED:		DATE:	
USERNAME:		PASSWORD:	
EMAILED RESPONSE TO:			
STAFF MEMBER'S SIGNATURE:		DATE:	