

Form for General Practitioner Registration

Please copy as required

*The National HPV Vaccination Program Register is fully funded by: Australian Government - Department of Health and Ageing
Operated by: Victorian Cytology Service Inc*

Instructions

This form is for General Practitioners to register with the National HPV Vaccine Program Register (NHVPR). One form is required for each Medicare Provider Number. General Practitioners wanting to receive Notification Payments as per *The National HPV Vaccination Program Register Act 2007* are required to supply bank account details as requested below.

Complete all fields in large clear BLOCK LETTERS.

General Practitioner details

Medicare provider number _____ Title _____
First name _____ Middle name _____
Surname _____ Phone number () _____
Email _____

(for primary contact, registry updates and distribution of online access password etc)

Business details

Business Name _____
Business ABN _____ GST Registered Yes No

Business address (please note that this address will be verified through Medicare)

Street _____
Suburb _____
State _____ Postcode _____

Contact person for business

First name _____ Surname _____
Phone number () _____ Fax number () _____
Email _____ *(to communicate payment details)*

Bank Account details (must be provided for payment of notifications received for 12 to 26 year old females)

Bank/ Institution _____
Branch _____
BSB number _____
Account number _____
Account name _____

*Please check bank account
details to ensure they are
correct.*

Do you intend to use the Register's online facilities to submit vaccine notifications electronically or to check the immunisation status of individuals using online facilities? (tick)

If Yes, then an Online Access Pack will be sent to you. Your user login will be posted to your address on the Medicare Provider List. The password to login will be emailed to the GP email address provided above.

Declaration and signature

I certify that the information provided on this notification form is complete and correct.

Signature _____ Date ____ / ____ / ____

Please fax this form to (03) 8360 8273

For assistance in submitting this form or for enquiries please call 1800 478 734 (1800 HPV REG)