



# APPLICATION FOR REGISTERED ACCOUNT

(Please print)

BUSINESS NAME: \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

OWNER NAME: \_\_\_\_\_

(Please include Professional Designation) \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_  
(If other than above)

**TYPE OF BUSINESS:**

Medical Doctor     Chiropractor     Physiotherapist     Athletic Therapist

Dentist     Denturist     Optometrist     Psychologist

Vocational Rehab Specialist     Grief Counselling Only (with prescription)

Elder (as confirmed with Band Council)

Ordained member of the Clergy

MISCELLANEOUS BI

Please provide description of business, professional designation, and license no.

\_\_\_\_\_  
\_\_\_\_\_

**LIST NAMES OF ALL HEALTH CARE PROVIDERS PRACTICING WITHIN THIS CLINIC**

(Please include owner and their professional designation.)

NAME	PROFESSIONAL DESIGNATION AND LICENSE NO.
_____	_____
_____	_____
_____	_____
_____	_____

THE ABOVE INFORMATION IS TRUE AND CORRECT (Please print)

NAME \_\_\_\_\_ TITLE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Email your form to: [InfoHealthCareServices@mpi.mb.ca](mailto:InfoHealthCareServices@mpi.mb.ca)

Any questions can be directed to [BIPaymentUnit@mpi.mb.ca](mailto:BIPaymentUnit@mpi.mb.ca) or (204) 985-8770 ext. 8246