Health PEI
One Island Health System

Santé Î.-P.-É.
Un système de santé unique

Adult Mental Health Practice Support Program Registration

Please review the "Requirements to Participate" document before submitting this form

Your Name: _____

Address: _____

E-mail: _____Tel: _____

Special dietary requirements: _____

	Medical Office Assistant 1	Medical Office Assistant 2
Name*		
E-mail Address		
Telephone #		
Special dietary requirements		

***If your Medical Office Assistant(s) (MOA) is employed by someone other than yourself, please ensure their employer is okay with their participation in the Program and provide the following information:**

MOA Employer Name: _____

Address: _____

E-mail: _____Tel: _____

Please send completed form to Iva Marinov at imarinov@ihis.org