University of Calgary Medical Group

Please Print Clearly

Member Name

Last: _____ First: _____ Middle: _____

Birth Date: _____
(Year/Month/Day)

Email: _____

Practitioner ID#: _____

Department: _____

Primary Skill Code: _____ Secondary Skill Code (If applicable): _____

Business Arrangement #: _____ Start Date: _____

Facility where office is located: _____

Employment Status: ◉ GFT ○ Major Clinical ○ Associate ○ Non-Member

Payment Method: ◉ AMHSP ○ FFS

Office Address

Street: _____

City: _____ Province: _____ Postal Code: _____

Phone #: _____

Home Address

Street: _____

City: _____ Province: _____ Postal Code: _____

Phone #: _____

Administrative Assistant: _____ Phone Number: _____

This information is collected under the authority of the Freedom of Information and Protection of Privacy Act. It is required to register you in our data base as a UCMG member, and will be used for mailing, report, and statistical purposes. If you have any questions about the collection or use of this information, please contact the Manager of Member Accounts (220-4319) of UCMG Accounting Services, or UCMGbilling@ucalgary.ca.