

CERTIFIED GAPS PRACTITIONER REGISTRATION

First Name/s:

Last Name:

Practice/Business Name:

Business Address:

Street/Number

Town/City

State/County

Zip Code/Post Code

Country

Business Phone:

Business Fax:

e-mail:

Web Site:

Professional Qualifications:

Areas of Special Interest:

Are you in active practice and ready to receive GAPS clients now?

Username for Log In:

(minimum 8, maximum 12 characters.

At least one alpha and at least one numeric. No symbols)

Password for Log In:

(minimum 8, maximum 12 characters.

At least one alpha and at least one numeric. No symbols)

**Once complete please return this form to
medinform@lineone.net**

THIS SERVICE IS ONLY AVAILABLE TO PRACTITIONERS WHO HAVE COMPLETED
THE CERTIFIED GAPS PRACTITIONER TRAINING COURSE