VENUES WEST

HEALTH AND FITNESS CENTRE

INSURANCE APPROVED EXERCISE PROGRAM REQUEST

DATE:

REHABILITATION PROVIDER Complete all details in block letters		
Practice name		
Therapist name		
Address	Suburb	Postcode
Email		
Phone	Mobile	

MEMBERSHIP REQUEST DETAILS		
☐ 3 months gym / pool membership	☐ 10 x pool passes (12 month expiry)	☐ 20 x pool passes (12 month expiry)

CLIENT INFORMATION		
Surname		Date of birth day / mo / year
First name		
Address	Suburb	Postcode
Email		
Phone	Mobile	
Claim number	Membership start date	

INVOICING DETAILS - invoice payable within 7 days	
Practice name	
☐ Invoice practice	☐ Pay at gym reception on 1st visit