MLW CLIENT ACCOUNT CHANGE REQUEST

CLIENT INFORMATION (MUST BE COMPLETED IN FULL)

Physician or Clinic Name: _____

Physician No: _____ **CPSO Registration No:** _____

Phone 1: _____ **Phone 2:** _____ **Fax:** _____

Address: _____

_____

After Hours Critical Result Contact: _____

CHANGE CATEGORY

□ **NEW** □ **ADDRESS CHANGE** □ **PHONE/FAX CHANGE**

□ **OFFICE CLOSURE** □ **PHYSICIAN NO LONGER PRACTICING** □ **CHANGE IN SERVICE**

□ **OFFICE HOUR CHANGE – PERMANENT** □ **OFFICE HOUR CHANGE – TEMPORARY**

□ **AUTOFAX REQUEST** □ **EMR LIVE** □ **COURIER SERVICE CHANGE**

Date of Request: _____ **Requested by:** _____

Effective Change Date: _____

Contact Person: _____ **Contact Phone #:** _____

DETAILS OF CHANGE:

_____

_____

_____

_____

Electronic Health Record (EMR) Software Package: □ **yes** □ **no**

If yes: **Name:** _____

Version: _____