

AFFILIATE REGISTRATION FORM

(PLEASE PRINT)

First Name: _____ Last Name: _____

Professional Designation: _____

Office Manager/Assistant Name: _____ Email: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

Phone (work) : _____ Phone (other) : _____

Email: _____ Fax: _____

Specialty of Practice: _____

Type of Practice: Sole Proprietorship Partnership
Clinic Group Name of Group: _____ # of Docs: _____

Commission Check Information:

Name or Clinic payable to: _____

Tax ID-SS #: _____

Please complete Affiliate Registration Form and Fax to: 1-800-379-6374

If you have and questions or concerns please contact:

Lindsay Genereaux, SENIOR NUTRITIONIST or **Nicole Kortis**, SENIOR NUTRITIONIST
1-800-379-9979