Information Submission Form

ScotiaHealth Network

Please complete the information form and fax toll free to 1-866-859-1785

Organization Name:_____

Physical Address:_____/_____
Unit/Apt Address

_____ / _____ / _____
City Prov. Postal Code

Mailing Address: Same as above ☐

Mailing Address: _____/_____
Unit/Apt Address

_____ / _____ / _____
City Prov. Postal Code

Contact Name: _____/ _____
First & Last Name Position at Facility

Tel: _(_____)_____ Fax:_(_____)_____

Email Address:_____

Comments:

Office Use Only:

An SHN representative will contact you within 24 hours of receipt of this form.