GeneSight® IMPACT Clinic Registration Form

Clinic Name:		
Phone:	Fax:	
Address:		
City:	Province:	Postal Code:

Enter information for the authorized Healthcare Providers who will place IMPACT orders and have access to view all IMPACT order reports for this clinic:

Name:	
Phone:	Fax:
E-mail:	Medical License Number:
Receive e-mail alert when packages are received by Assurex Health?	Yes ☐ No ☐

Name:	
Phone:	Fax:
E-mail:	Medical License Number:
Receive e-mail alert when packages are received by Assurex Health?	Yes ☐ No ☐

Name:	
Phone:	Fax:
E-mail:	Medical License Number:
Receive e-mail alert when packages are received by Assurex Health?	Yes ☐ No ☐

Name:	
Phone:	Fax:
E-mail:	Medical License Number:
Receive e-mail alert when packages are received by Assurex Health?	Yes ☐ No ☐

Name:	
Phone:	Fax:
E-mail:	Medical License Number:
Receive e-mail alert when packages are received by Assurex Health?	Yes ☐ No ☐

Name:	
Phone:	Fax:
E-mail:	Medical License Number:
Receive e-mail alert when packages are received by Assurex Health?	Yes ☐ No ☐

Name:	
Phone:	Fax:
E-mail:	Medical License Number:
Receive e-mail alert when packages are received by Assurex Health?	Yes ☐ No ☐

GeneSight® IMPACT User Registration Form

Clinic/Facility Name: _____

If there are individuals at your IMPACT facility who are not ordering healthcare providers who will have access to the IMPACT orders for this clinic, enter their information below:

Name:	
Job Title:	
Phone:	Fax:
E-mail:	

User is authorized to perform the following actions for the healthcare providers listed below (check all that apply):

All registered healthcare providers at clinic/facility: Place Orders: ☐ View Reports: ☐

OR

Name: _____ Place Orders: ☐ View Reports: ☐

Name: _____ Place Orders: ☐ View Reports: ☐

Name: _____ Place Orders: ☐ View Reports: ☐

Name: _____ Place Orders: ☐ View Reports: ☐

Name: _____ Place Orders: ☐ View Reports: ☐

Name:	
Job Title:	
Phone:	Fax:
E-mail:	

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Name: _____ Place Orders: ☐ View Reports: ☐

Name: _____ Place Orders: ☐ View Reports: ☐