

Skin Audit Registration Form

Please complete all sections below. Please note: Supplying your email address, and the name and registration number of your college, will allow us to allocate your education points.

DOCTOR INFORMATION

Title: _____ First Name: _____ Last Name: _____

Dorevitch Dr. Code (if known): _____ Provider No.: _____

Name of College: _____ College Registration No.: _____

Mandatory

Practitioner Type

- General Practitioner
 Skin Cancer Practitioner
 Plastic / General Surgeon
 Dermatologist

Use of Dermoscopy:

- No
 Always
 Sometimes

Use of Sequential Digital Imaging:

- Yes
 No

PRACTICE DETAILS

Practice Name (Primary Location): _____

Practice Address (Primary Location): _____

Suburb: _____ State: _____ Postcode: _____

Phone: _____ Fax: _____ Mobile: _____

Email Address: _____

Required

Other practice locations to be included in this audit: _____

FREQUENCY OF REPORTS Half Yearly Yearly

I, Dr _____ (print name) confirm that I wish to receive a 'Skin Audit Report' of my pathology cases and I will contact Dorevitch Pathology if my contact details change or if I no longer want to receive the 'Skin Audit Report'.

Doctor's Signature _____ Date: _____

Scan and email, or fax completed registration form to
DorevitchSkinAudit@dorevitch.com.au / (03) 9244 0486.

Confirmation of your registration will be emailed to you. Registered doctors will be provided Skin Audit Request Forms via your Medical Liaison Officer. If you do not receive your request forms within a week please contact your local laboratory. Both sides of the Skin Audit request form must be completed to ensure that all specimens are included in your audit data.

