Surgical Skin Audit Registration Form

Please email registration form to: WDPSkinAudit@wdp.com.au
OR download the Skin Audit Registration Form from our website: www.wdp.com.au under "I am a doctor" tab.

Doctor Information

Title:	First Name:	Last Name:	Provider No:
WDP Dr. Code (if known):		RACGP QI & CPD/ACRRM No: REQUIRED TO OBTAIN CPD POINTS	
Doctor Type: (please tick) ☐ General Practitioner ☐ Skin Cancer Practitioner ☐ Plastic / General Surgeon ☐ Dermatologist		Use of Dermoscopy: ☐ No ☐ Always ☐ Sometimes	Use of Sequential Digital Imaging: ☐ Yes ☐ No

Practice Details

Your Practice Name (primary location):	
Your Practice Address (primary location): Street: _____ Suburb: _____ Postcode: _____	Location Type: ☐ Major City ☐ Large City ☐ Rural / Remote
Phone No / Mobile No: _____ *You will be contacted on this number to be given your confidential username and password.*	
Email Address:	
Other Practice locations to be included in this audit:	**OFFICE USE:** Dr Codes Request Forms Letter of Confirmation

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 Western Diagnostic Pathology if my contact details change or if I no longer want to receive the 'Skin Audit Report'.

Doctor's Signature _____ Date _____

Please note: You will receive designated Skin Audit Request Forms within 2 weeks of registration. If you do not receive your designated Skin Audit Request Forms within 2 weeks of submitting this form, please email WDPSkinAudit@wdp.com.au OR contact your Medical Liaison Officer.