EHIS HEALTHCARE PROVIDER REGISTRATION FORM

All Fields with Asterix (*) are Required

Healthcare Provider Name (Organization)*:

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Organization Role *: Healthcare Provider/Sponsor

Healthcare Provider Type*: Primary Healthcare Facility/Secondary Healthcare Facility/Tertiary Healthcare Facility

Services Offered*: Inpatient/Laboratory/Ophthalmology/Outpatient/Pharmaceutical/Radiological

CONTACT MECHANISM

Telecommunications:

Phone*: (+234)……... Desk Office Phone: (+234)…….

Alternate: (+234)……..

Electronic:

Primary E-Mail: …….

Alternate E-mail …….

Work E-Mail: …….

Website: …….

Facebook: ……

Twitter: ……

POSTAL ADDRESS

Facility Address*: ……

……..

……..

State*:…….. Local Government*: ……