**Bariatric Surgery Registry**

**SURGEON REGISTRATION FORM**

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| **Name:**  |  |

I am pleased to contribute my bariatric patients to the Registry.

My private practice details are (preferred address for Registry contact):

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| **Address Line 1:**  |  |
| **Address Line 2:**  |  |
| **Suburb / Postcode/ State:**  |  |
| **Phone number:**  |  |
| **Fax number:**  |  |
| **E-mail:**  |  |

My bariatric hospital associations are:

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| **(Principal) Hospital Site:**  |  |
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