Phone: 780-461-2111

Email: bookings@albertaeyemd.com

AlbertaEye MD

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Affiliate doctor information

Last name: First name:

Designation (OD/MD/DO): Phone number: ( )

Personal email address:

LIST OF LOCATIONS YOU ARE REFERRING FROM

Practice information

Clinic name:

Practice phone number: ( ) Fax number: ( )

Address (number, street, suite):

City: Province/state: Postal/zip code:

PAYMENT OPTIONS

☐ **Electronic Funds Transfer (EFT) Payment -** You **must** include **both:**

1. A void cheque
2. A payment confirmation email:

☐ **Cheque Payment -** You **must** include **both:**

1. Cheque to be made out to:
2. Mailing Address:

Additional practice information

Clinic name:

Practice phone number: ( ) Fax number: ( )

Address (number, street, suite):

City: Province/state: Postal/zip code:

PAYMENT OPTIONS

☐ **Electronic Funds Transfer (EFT) Payment -** You **must** include **both:**

1. A void cheque
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☐ **Cheque Payment** - You **must** include **both:**

1. Cheque to be made out to:
2. Mailing Address:

Please E-mail the completed form with an attached referral letter to: **bookings@albertaeyemd.com**