



Clinic Permit Application

Clinic Name: _____

Address: _____ Phone: _____
_____ FAX: _____
_____ email: _____

Incorporated: yes _____ No _____ Date: _____

Insurance Company: _____

Clinic Owner: _____ Clinic Manager: _____

Clinic Employees: _____ Duties: _____
_____ _____
_____ _____

Current fee structure for services offered: _____

Floor Plan: (attach a copy)

It is the clinic responsibility to ensure that all therapists are licenced and that the Council is informed of any staffing changes.

I hereby acknowledge that the information given is correct and complete.

Signature Date