www.VasectomyMedical.com

Registration Form

Fax to: 604 224-4233

This form must be filled out completely (Print Clearly or Type).

Note: ***Your listing cannot be activated without an e-mail address***

Bonus – Send (mail or email, don't fax) your picture for your listing.

First name: _____ Last name: _____

Circle: MD / FACS / FRCPC / other: _____

Full Address (incl. clinic name): _____

_____

City: _____ State/Prov: _____ Zip: _____

Email Address: _____

Phone #: _____ Fax #: _____

Practice Description (to accompany your listing – very important) Print clearly or type:

_____
_____
_____
_____
_____

Service Performed: Vasectomy – YES / NO if yes, scalpel OR no-scalpel?
Vasectomy Reversal – YES / NO

Name of your website:

_____

Are you interested in receiving a large increase in referrals? Let us know and we'll let you know about the paid subscription service? YES / NO.

COMMENTS:

_____
_____
_____
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