

## Registration with a nurse practitioner specialized in primary care

### 1. INFORMATION ON THE NURSE PRACTITIONER SPECIALIZED IN PRIMARY CARE

FIRST NAME	LAST NAME	PRACTICE NUMBER (RAMQ) 8 1
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### 2. INFORMATION ON THE FAMILY MEDICINE GROUP ▶ You must fill out this section only if you are a member of the Family Medicine Group with which the patient agrees to register.

NAME OF FAMILY MEDICINE GROUP	REFERENCE NUMBER OF FAMILY MEDICINE GROUP	FILE NUMBER
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### 3. INFORMATION ON THE INSURED PERSON

FIRST NAME		LAST NAME AT BIRTH			HEALTH INSURANCE NUMBER			
DATE OF BIRTH Y Y Y Y   M M   D D	SEX <input type="checkbox"/> M <input type="checkbox"/> F	AREA CODE	TELEPHONE (HOME)	AREA CODE	TELEPHONE (WORK)	EXT.	LANGUAGE OF CORRESPONDENCE <input type="checkbox"/> French <input type="checkbox"/> English	
MAILING ADDRESS NUMBER	STREET						APARTMENT	
MUNICIPALITY				PROVINCE			POSTAL CODE	

### 4. FOLLOW-UP LOCATION AND HEALTH CHARACTERISTICS

NAME OF SERVICE POINT (USUAL FOLLOW-UP LOCATION)	CODE	START DATE OF CODE Y Y Y Y   M M   D D	CODE	START DATE OF CODE Y Y Y Y   M M   D D
NUMBER OF SERVICE POINT	START DATE OF SERVICE POINT DESIGNATION Y Y Y Y   M M   D D	CODE	START DATE OF CODE Y Y Y Y   M M   D D	

### 5. STATEMENT BY THE INSURED PERSON

I declare that all the information provided is accurate. I designate the person named in section 1 to be my sole nurse practitioner specialized in primary care and hereby cancel any previous registration with a nurse practitioner or family doctor, if applicable. If I should change health professional, I understand that the name of my new health professional and the place of my new registration will be disclosed to my former health professional.

SIGNATURE	DATE Y Y Y Y   M M   D D
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### 6. SECTION TO BE COMPLETED BY THE REPRESENTATIVE OF THE INSURED PERSON WHO IS UNDER AGE OR INCAPACITATED

FIRST AND LAST NAMES OF THE PARENT, GUARDIAN, MANDATARY, TRUSTEE OR ACCOMPANYING PERSON	FOR A CHILD UNDER AGE 1 WHO DOES NOT HAVE A HEALTH INSURANCE CARD, ENTER THE HEALTH INSURANCE NUMBER OF THE MOTHER OR FATHER.						
MAILING ADDRESS NUMBER	STREET			APARTMENT			
MUNICIPALITY		PROVINCE			POSTAL CODE		
<input type="checkbox"/> Mother or father	<input type="checkbox"/> Guardian	<input type="checkbox"/> Trustee	AREA CODE	TELEPHONE (HOME)	AREA CODE	TELEPHONE (WORK)	EXT.
<input type="checkbox"/> Mandatary	<input type="checkbox"/> Accompanying person						
SIGNATURE						DATE Y Y Y Y   M M   D D	

### 7. STATEMENT BY THE NURSE PRACTITIONER SPECIALIZED IN PRIMARY CARE

In accordance with the Code of ethics of nurses, I agree to be the nurse practitioner specialized in primary care for the person identified in section 3.

SIGNATURE	PRACTICE NUMBER (RAMQ) 8 1	DATE Y Y Y Y   M M   D D
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**Note:** The first and last names and Health Insurance Number of the insured person will be sent to us for the purposes of the application of the *Health Insurance Act*.

**EACH SIGNING PARTY KEEPS ONE COPY.**

## Instructions

### IMPORTANT

- Fill out **one form only** per person **in block letters**.
- Do not send us a **paper version** of this form.
- No registrations will be accepted by telephone, fax or mail.

### **Registration of an insured person with a nurse practitioner specialized in primary care affiliated with a Family Medicine Group or not affiliated with a Family Medicine Group**

- 1) Fill out section 1. The practice number corresponds to the number assigned by RAMQ (81XXXX) and not to your permit number from the Ordre des infirmières et infirmiers du Québec.
- 2) Fill out section 2 only if you are affiliated with a Family Medicine Group. The Family Medicine Group reference number corresponds to the number issued by RAMQ (4 digits).
- 3) Fill out the appropriate sections, according to the situation of the insured person (sections 3, 4 and 6).
- 4) Have the form signed by the insured person (section 5).
- 5) Sign the form (section 7).
- 6) Give one copy of the signed form to the insured person or to the person's representative and keep the original copy in the insured person's file.
- 7) Send the form using our online service or a RAMQ-approved registration software.
- 8) Have the [Consent form for the sharing and release of user information](#) signed by the insured person or by the person's representative and keep the original in the insured person's file.