

# Health Care Provider Registration Agreement

For office use only

PO Box 201410, Helena, MT 59620-1410 • Phone (406) 444-0660 or (866) 675-3314 • E-mail: [endofliferegistry@mt.gov](mailto:endofliferegistry@mt.gov)

This form is used by health care providers to register for access to the repository of advance directives available online through the Montana End-of-Life Registry.

- Complete this Agreement and return it to the address above to request your End-of-Life Registry user name and password.
- Your request will be processed within three weeks and you will receive further information in the mail.
- For further assistance, please contact the Office of Consumer Protection at the address above.

Facility Type: (check one)				
<input type="checkbox"/> Ambulatory Surgery Facility	<input type="checkbox"/> Hospice	<input type="checkbox"/> Private Office		
<input type="checkbox"/> Clinic	<input type="checkbox"/> Hospital	<input type="checkbox"/> Other _____		
<input type="checkbox"/> Home Health Care Agency	<input type="checkbox"/> Nursing Facility			
Name of Health Care Facility or Provider		Facility ID No. or Health Care Provider License No.	ID or License No. Expiration Date	
Department (optional)				
E-mail Address (optional)				
Mailing Address				
City	State	Zip	Telephone	Fax