Register as a practitioner

Please allow 1 – 2 days to allow for verification

Amipro

Your Details

Name & Surname _____

Practitioner Type _____

Please attach copy of medical qualifications when returning this form.

Your Health Interests / Specialty

Choose Any

- ☐ General Wellness
- ☐ Weight Management
- ☐ Inflammatory conditions
- ☐ Cardiovascular health
- ☐ Women's Health
- ☐ Gastrointestinal Health
- ☐ Neurological health
- ☐ Autoimmune conditions
- ☐ Men's Health
- ☐ Metabolic detoxification
- ☐ Sports Nutrition
- ☐ Other
- ☐ Children's Health

Practice Details

Practice email _____

Practice contact number _____

Practice Website _____

If other, please list _____

Street Address

Street address _____

Suburb, City, Province _____

Postal Code _____

Country _____

Accounts department

Accounts contact person _____

Accounts contact number _____

Accounts email _____

Have you consulted with one of our representatives (yes/no)?

If yes, please provide details _____

Do you sell products from your practice? Yes ☐ No ☐ No but I would like to ☐

How did you hear about us? Other _____

Website Practitioner Portal

Email address _____

Password _____

Your login details will be emailed to you once your www.amipro.co.za website profile has been set up.

Would you like to receive email marketing from us? Yes ☐ No ☐

SUBMIT