eReports™ Registration Form

Last Name:	First Name:

Practice/Facility Name:		
☐ Hearing Screener	☐ Audiologist	☐ Nurse
☐ Data Entry Clerk	☐ Physician	☐ Other___________________

Phone: ( ) - Ext:	Fax: ( ) -

Address:		
City:	State:	Zip:

Email Address:	Verify Email:

FOR NBS STAFF ONLY	
Request was: ☐ Approved ☐ Denied Date Approved or Denied:	
Please Login immediately after receiving your Username and Password.	
User Name:	Password:

Questions? Please call (850)245-4201 option 4.