

APPLICANT DETAILS				
Family Name:		Employee Payroll Number:		
Given Name:		Preferred Name:		
Home Address:				
				Post Code:
Phone Home:	Mobile:	Work:		
Email:		Pager:		
Position:		Department:		
Work Location:				
Please Tick				
<input type="checkbox"/>	South Metropolitan Health Service		<input type="checkbox"/>	Other Metropolitan Health Service
<input type="checkbox"/>	Other Employer - Please Specify:			
Other Employer's Address:				
				Post Code:
COURSE DETAILS (please write clearly the name and date of the course)				
Title:				
Date/s:		Time:	Cost:	
Payee Responsible (if applicable):		<input type="checkbox"/> Self	<input type="checkbox"/> Employer	
Notification confirming acceptance and/or a Remittance Advice will be forwarded to you within 10 days of the closing date. Pre-course material, if applicable, will be forwarded after payment has been received. One week's notice of cancellation is required to receive a refund.				
MANAGER APPROVAL (Details of Manager approval & journal transfer must be completed as applicable or the form will be returned to the applicant)				
Name:		Position:		
HE Number:		Date:		
Phone:		Signature:		
Registration form forwarded to The Education Centre Y / N (This is the employee's responsibility)				
COURSE PAYMENT DEBIT ADVICE AUTHORISATION (Manager use only)				
(Only complete this section if a fee applies and the Health Service is funding this application)				
Amount	Entity Number	Cost Centre	Account	Fund
Cost Centre Approving Officer's Name:				
Signature:		Date:		

Completed forms must be received by course closing date via fax or mail to: Fax: 9224 2255
The Education Centre
Ground Floor, WASON Building
Royal Perth Hospital
GPO Box X2213 PERTH WA 6847