Government of **Western Australia**
Department of **Health**

ROYAL COLLEGE of NURSING Australia

The Department of Health and the Royal College of Nursing, Australia

Tax invoice ABN 28 684 750 332

RN/EN, Allied Health Care Workers Education Enrolment Form

Immunisation Certification Program: Excellence in Immunisation, Theory and Clinical Competency

Please complete all parts of this form and type or print clearly
Registration and payment is required by COB on the 10th of the month prior to starting your course

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ENROLMENT MONTH _____ **Year** _____

PERSONAL DETAILS **(All fields must be completed – Please Print Clearly)**

Title (Miss, Ms, Mrs, Mr etc) _____ Surname _____ First name _____

Other name _____

Address _____ Suburb/Town _____ Postcode _____

Mobile no. _____ Home no. ( ) _____

Email address _____

Delivery of Student packages (if different to above address) _____

_____ Postcode _____

Applicants Signature _____ Date _____

EMPLOYMENT DETAILS **(All fields must be completed – Please Print Clearly)**

Staff position _____ Ward/PHU/GP Surgery/etc _____

Place of Employment _____

Area Health Service _____

Work telephone ( ) _____

Speciality _____

PAYMENT **(course fee of $100 is required with your enrolment form by COB on the 10th of each month)**

Cheque/Money Order (Complete this section if you or your employer is paying by cheque or money order)

☐ Please find enclosed a cheque/money order for the sum of $100 made payable to ***Department of Health WA***

OR

BY EMPLOYER **(Complete this section only if your employer is paying for your course fees)**

☐ Journal Transfer will only be accepted from Department of Health area/regional health services. Enrolment cannot be confirmed unless the total fee payable is included or authorized.

Course fees will be paid by _____

Journal Transfer (for DoH staff only); Cost Centre Number _____ Entity Number _____

Account Number _____ RIC/Managers name (Please print) _____

Signature _____ Contact no. _____

SUPERVISOR/ASSESSOR DETAILS **(to be completed by supervisor/assessor/course coordinator)**

Supervisor allocated to student _____ Supervisor's contact no. _____

Supervisor form completed and sent to DoH ☐ **Yes** ☐ **No** Place of Employment _____

Assessor allocated to student _____ Assessor's contact no. _____

Assessor form completed and sent to DoH ☐ **Yes** ☐ **No**

PLEASE POST COMPLETED ENROLMENT FORM AND PAYMENT TO:

Palee Kaur, Communicable Disease Control Directorate PO Box 8172 Perth Business Centre WA 6849
Telephone: 93884863 Fax 9388 4877

*The Department of Health reserves the right to refuse an enrolment and to cancel or suspend the course at any time in the event of an unexpected work situation e.g. pandemic occurs and resources are diverted to this. If the Department of Health cancels a course, a refund will be made of the full course fee.