

TRAINING APPLICATION 2020

Please ensure you complete all fields clearly

APPLICANT DETAILS

Title			
First name:		Surname:	
Address:	Residential: Unit no. _____ Street no. _____ Street name: _____ Suburb: _____ City: _____ Postcode: _____ Postal: _____		
Phone	Work:	Mobile:	
	Home:	USI #	
Email:	Work:	<input type="checkbox"/>	
	Private	<input type="checkbox"/>	
Please tick preferred – FPWNT use email as primary method of contact for training			
Emergency contact person	Name:	Relationship:	
	Phone:	Alternative contact number:	
Do you have any special dietary requirements?			

EMPLOYMENT DETAILS

Job title:	
Who do you work for:	Place of Work: Phone: Address:
Doctors only:	QI & CPD number:

DEMOGRAPHIC DETAILS

DOB		GENDER		TOWN OF BIRTH	
Are you an Australian Citizen or Permanent Resident?				Yes / No	
Language spoken at home:					
Do you have any disability or require special assistance? If so please provide detail below:					
Are you of Aboriginal or Torres Strait Islander origin? (please tick)					
No <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/>					
Work status (circle):		Full time / part time / casual / student / unemployed			
Please indicate the highest level of qualifications completed since leaving school (please tick)		Bachelor's degree or higher <input type="checkbox"/> Advanced/associate diploma <input type="checkbox"/> Certificate III / IV advanced trade <input type="checkbox"/> Other <input type="checkbox"/>			
What year was this qualification obtained?					

PLEASE INDICATE THE TRAINING YOU ARE APPLYING FOR:

Training	Location	Dates	Cost	Tick	Implanon NXT TICK
Well Women's Health Unit (HLTAHW027) <i>Provide Information & Strategies in Sexual Health for Women. PLUS optional Progesterone Implant NXT training</i>	Darwin	2nd – 6 th MARCH	\$1,555		
	Darwin	27 th – 31 st JULY	\$1,555		
	Darwin	16 th – 20 th NOVEMBER	\$1,555		
	Alice Springs	20 th - 24 th APRIL	\$1,555		
	Nhulunbuy	12 th – 16 th OCTOBER	\$1,555		
	Note: ALL DoH employees are free. Places are limited.				
Cost listed for Well Women's Health Unit includes both theory and clinical training. Please discuss with administration officer if you wish to do the theory component only – the price will be adjusted accordingly.					
Reproductive & Sexual Health Course for NURSES	Darwin	15 th – 19 th JUNE	\$1,155		NA
PROGESTONE IMPLANT NXT WORKSHOP for DOCTORS	Darwin	Dates TBC	TBC		NA
AHP only, course in men's and women's sexual health	If Interest please contact admin@fpwnt.com.au				NA
Family Planning's 'Participant information handbook' is available to read on our website www.fpwnt.com.au					

REASON FOR FURTHER STUDY

Of the following categories, please tick which BEST describes your main reason for training:	
To get a job	<input type="checkbox"/>
To get a better job or promotion	<input type="checkbox"/>
For personal interest or self-development	<input type="checkbox"/>
It is a requirement of my job	<input type="checkbox"/>
I wanted extra skills for my job	<input type="checkbox"/>
To start my own business	<input type="checkbox"/>
To develop my existing business	<input type="checkbox"/>
To get into another course of study	<input type="checkbox"/>
Other (please specify): _____	<input type="checkbox"/>

PAYMENT METHOD (Please tick)

<input type="checkbox"/> Participant funded Payment will be invoiced and is due <u>prior</u> to the unit commencing. To discuss payment plan options please contact the Administration officer, admin@fpwnt.com.au								
<input type="checkbox"/> Department of Health funded employee Funded under the partnership between FPWNT and the Top End Health Services. (We suggest you contact your regions DoH Well Women's Educator to confirm placement).								
<input type="checkbox"/> Employer funded Please provide a copy of the purchase order and/or details for invoicing <table border="1" style="width: 100%;"> <tr> <td>Contact person:</td> <td></td> </tr> <tr> <td>Phone number:</td> <td></td> </tr> <tr> <td>Address for invoice</td> <td></td> </tr> <tr> <td>Employer Name and signature:</td> <td></td> </tr> </table>	Contact person:		Phone number:		Address for invoice		Employer Name and signature:	
Contact person:								
Phone number:								
Address for invoice								
Employer Name and signature:								
Family Planning's 'Training courses & fee refund policy' is available to read on our website www.fpwnt.com.au								

PRIVACY, CONFIDENTIALITY AND SECURITY AGREEMENT

Family Planning Welfare Association NT [FPWNT] is committed to ensuring we comply with relevant privacy, confidentiality and security legislation – to protect our clients, our staff and our organisation. As a part of this, individuals are required to understand their obligations and responsibilities including what it means to sign this privacy, confidentiality and security agreement.

All persons, including FPWNT employees, contractors, volunteers and students who come into contact with, or have access to, confidential information have a responsibility to maintain privacy, confidentiality and security of that information. Confidential information may include (but is not limited to) information relating to:

- Clients and/or family members e.g. health records.
- Employees, contractors, volunteers, students e.g. salaries, employment records, disciplinary actions
- Third parties e.g. vendor contracts, computer programs, technology
- Business information e.g. financial records, reports, memos, contracts, computer programs, technology
- Operations improvement, quality assurance, peer review

FPWNT will ensure your personal training information is secure at all times. FPWNT will when required submit data sourced from this enrolment form to the national VET administrative collection as a regulatory requirement of our RTO compliance (third party). The information we collect may be therefore, requested by VET regulators and associated Government Departments and your employer –only if your employer paid for your training.

If you have any questions or concerns relating to privacy, confidentiality or security of information, please contact the Chief Executive Officer of FPWNT.

Declaration (*all applicants must complete*):

I (insert full name)....., declare that:

- I have read and understand my rights and responsibilities in regards to **privacy, confidentiality and security**.
- I have read and understand the information contained in FPWNT's **Participant Information Handbook**. I understand my rights and responsibilities as a training participant and *how my personal training information collected by FPWNT will be used*.
- I agree to abide by the above policies and procedures of FPWNT in regards to my conduct and actions throughout the course of my training and/or any clinical placement.
- To the best of my knowledge, the information given in this application is correct and complete. I understand and accept that FPWNT reserves the right to withdraw my offer of enrolment at any stage during my course where false or misleading information has been provided.
- I have read and agree to the terms of the '**Training course refund policy**' of FPWNT.
I understand my placement/ registration will not be confirmed until full payment (or Department of Health approval) has been received by Family Planning NT prior to the course.

Signature:_____ **Date:**_____

CHECKLIST – PLEASE TICK TO ENSURE YOUR APPLICATION IS COMPLETE	
Application form with ALL fields completed clearly	<input type="checkbox"/>
Signed declaration	<input type="checkbox"/>
Evidence of professional indemnity insurance – certificate	<input type="checkbox"/>
USI number (further information can be found on our website or contact us)	<input type="checkbox"/>
It is your responsibility to ensure your application is complete, and includes all required accompanying documentation as outlined on the checklist above. Incomplete applications will be delayed.	

FOR OFFICE USE ONLY (Administration officer to complete)	
I have received (tick):	
Completed application form with all fields printed clearly	<input type="checkbox"/>
Photocopy of professional registration certificate	<input type="checkbox"/>
Evidence of professional indemnity insurance – APHRA Check	<input type="checkbox"/>
USI number collected	<input type="checkbox"/>
<p>Is the application complete? Yes / No</p> <p>If not provide detail on missing information / documentation:</p> <p>Acceptance email sent on (insert date): Yes / No Course Fees: \$ _____</p> <p>Invoice No _____ Sent. _____ Paid: Yes / No</p> <p>Other:</p>	

END _____