

TRAINING APPLICATION FORM 2012

Applicant Details – Please complete all sections

FULL NAME:			GENDER:	
POSTAL ADDRESS:				
PHONE:	Work:	Home:		
	Mobile:	Fax:		
EMAIL:				
<i>Please tick (✓) if you are unable to receive contact/documents by email: <input type="checkbox"/></i>				
DATE OF BIRTH:		IS ENGLISH YOUR FIRST LANGUAGE?	Y	N
JOB TITLE:				
EMPLOYER/PLACE OF WORK:			LENGTH OF EMPLOYMENT:	
**PROFESSIONAL REGISTRATION:	Number:	Exp. Date:		
**OCHRE CARD:	Number:	Exp. Date:		
<i>**Please include a photocopy of your Registration Certificate and Ochre Card with your application.</i>				
DOCTORS ONLY:	QA & CPD #:	Medical Insurer:		

Do you have any special dietary requirements? No / Yes (Describe): _____

Do you have any special learning requirements? No / Yes (Describe): _____

Please tick if you do not wish to receive email newsletters from Family Planning NT:

<u>PAYMENT METHOD:</u> (please ✓)													
<input type="checkbox"/>	Department of Health Funded <ul style="list-style-type: none"> Please attach a copy of the HE47 Approval for Training Form 												
<input type="checkbox"/>	Employer Funded <ul style="list-style-type: none"> Please provide a copy of the purchase order and details for invoicing: <table border="1" style="width: 100%;"> <tr> <td>Contact Person:</td> <td></td> <td>Phone Number:</td> <td></td> </tr> <tr> <td colspan="4">Address for Invoice:</td> </tr> <tr> <td colspan="4">Employer Signature:</td> </tr> </table>	Contact Person:		Phone Number:		Address for Invoice:				Employer Signature:			
Contact Person:		Phone Number:											
Address for Invoice:													
Employer Signature:													
<input type="checkbox"/>	Participant Funded <ul style="list-style-type: none"> Please provide an address for invoicing Payment must be made prior to the commencement of training <table border="1" style="width: 100%;"> <tr> <td>Address/Email for Invoice:</td> <td></td> </tr> </table>	Address/Email for Invoice:											
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**PLEASE SEE COURSE-SPECIFIC BROCHURES
FOR INFORMATION ABOUT TRAINING.**

Which course are you applying for? (please ✓)

Course Name	Location	Dates (All 2012)	Cost	✓
Well Women's Health Screening (Non-DoH staff)	Darwin	20-24 Feb	\$1296 (incl.)	
Well Women's Health Screening (Non-DoH staff)	Darwin	10-14 Sep	\$1296 (incl.)	
Well Women's Health Screening (DoH funded)	Darwin	19-23 Mar	N/A	
Well Women's Health Screening (DoH funded)	Gove	4-8 Jun	N/A	
Well Women's Health Screening (Part DoH funded)	Katherine	27-31 Aug	N/A	
Well Women's Health Screening (DoH funded)	Darwin	29 Oct – 2 Nov	N/A	
Well Women's Health Screening (DoH funded)	Alice Springs	19-23 Nov	N/A	
Well Women's Health Screening (DoH funded)	Alice Springs	25 th – 29 th June	N/A	
Sexual and Reproductive Health Course (for Nurses) <ul style="list-style-type: none"> Theory component (5 days) Prerequisite: WWHS training 	Darwin	21-25 May	\$880 (incl.)	
Sexual and Reproductive Course (for Doctors) <ul style="list-style-type: none"> Theory component 	Darwin	9-13 Jul	\$1750 (incl.)	
Course in Men's Sexual Health (for Aboriginal Health Workers)	Alice Springs	16-20 Apr	N/A	
Course in Women's Sexual Health (for Aboriginal Health Workers)	Darwin	30 Jul – 3 Aug	\$990 (incl.)	

Please read Family Planning NT's Fee and Refund Policy which can be found on our website at <http://www.fpwnt.com.au/pages/Training-Courses-and-Education.html>. If you are unable to access the internet please contact our Administration Officer for a copy.

Declaration (all applicants must complete):

I declare that to the best of my knowledge the information given in this application is correct and complete. Family Planning NT 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 abide by the Fees and Refunds Policy of Family Planning NT. 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: _____

Please return completed application form to:

Administration Officer
Family Planning Welfare Association of the NT Inc
P.O. Box 503, Nightcliff NT 0814
(P): 08 8948 0144
(F): 08 8948 0626
(E): admin@fpwnt.com.au

FPWNT Administration Office to complete:

Acceptance letter posted Yes / No

Course Fees: \$ _____

Invoice No _____ Sent. _____

Paid Yes / No