Government of **Western Australia**
Department of **Health**
Child and Adolescent Health Service

Phone 9340 8926
Fax: 9340 8267

Application for Professional Development
PAEDIATRIC NURSING EDUCATION

APPLICANT DETAILS – Please print all details clearly		
Family Name:	Employee Payroll Number:	
Given Name:	Preferred Name: (this is the name as will be seen on your certificate)	
Home Address: Post Code:		
Phone Mobile:	Home:	Work:
Email (frequently used email address):		Pager:
Position:	Department:	
Work Location (Please circle):		
PMH / Community Health	Other Employer: (Please specify)	
Dietary Requirements: Please advise of any dietary requirements you may have:		

COURSE DETAILS (please write clearly the name and date of the course)		
Title:		
Date:	Time:	Cost:
Payee Responsible (please circle):	Self	Employer **COST CENTRE:**

TO BE COMPLETED BY AUTHORISING OFFICER (PMH Staff only)		
Name:	He Number:	
Position:	**Cost Centre:**	
Signature:	Date:	Telephone:

CANCELLATION POLICY
Cancellation of enrolment will result in a fee being levied
20% will be retained if cancellation within 1 week (7 days) of activity
50% will be retained if cancellation one day prior to activity
No refund will be given for non attendance if NO notification of cancellation is given

- **Please forward application to either pmh.pne@health.wa.gov.au or post to Paediatric Nursing Education, Princess Margaret Hospital, PO BOX D184, PERTH WA 6840 or Fax to 08 9340 8267**
- Please note: Due to unforeseen circumstances, the program coordinator may need to alter content or speakers at short notice
- An email will be sent confirming your registration including a map. If payment was made via cheque or credit card, a receipt will be given to you on the day

CREDIT CARD PAYMENT SLIP

STUDY DAY: _____ **AMOUNT:** $_____

NAME: _____ **CARD No:** _____/_____/_____/_____

CARD TYPE: VISA □ MASTERCARD □ **EXPIRY DATE:** _____/_____

SIGNATURE: _____