**INTRODUCTORY CERTIFICATE OF PERINATAL MENTAL HEALTH**

**ENROLMENT & PAYMENT FORM**

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| --- | --- |
| **COURSE:** | *10 Week Introductory Certificate of Perinatal Mental Health* |
| **DATE:** | *2nd May to 4th July, 2018.*  *(Wednesday afternoons from 3:00pm - 6:00pm)* |
| **VENUE:** | *Helen Mayo House, Glenside Campus*  *226 Fullarton Rd, Glenside* |
| **COST:** | *$600*  *$300 for CAMHS Staff*  *No cost to Helen Mayo House Staff* |

**STUDENT DETAILS**

|  |  |
| --- | --- |
| **NAME:** |  |
| **PHONE:** |  |
| **MOBILE:** |  |
| **CURRENT**  **POSITION:** |  |
| **WORKPLACE:** |  |
| **QUALIFICATIONS:** |  |
| **WORK ADDRESS:** |  |
| **WORK POSTAL**  **ADDRESS:** |  |
| **EMAIL ADDRESS:**  **(Email required)** |  |

*PLEASE NOTE: Our course does not provide indemnity for you or your attendance at any lectures or other training related to this course. You may want to check with your workplace if their insurance will cover you. Please note by signing the enrolment form, you confirm you have insurance.*

*Signature:*

*Date:*

**PAYMENT DETAILS**

*Select one of the following:*

☐ Employed by SA Health - *Specify department:*

☐ I work for another government agency – *Specify agency -*

☐ I work for a non-government agency

☐ Other, please specify -

**FOR NON SA HEALTH EMPLOYEES**

Once you have returned this form and are accepted into the course, a tax invoice will be generated and sent to the person or organisation you have indicated below as being responsible for payment.

**FOR SA HEALTH EMPLOYEES**

If your organisation has agreed to pay for the course please tick organisation and complete the form on page 4. If multiple employees have applied to attend this course from your department, could you please place them on the one form. We will attempt to have your invoice paid via a journal transfer, however SA Health will not process transfers between networks of less than $1,000. If a journal is not possible, we will contact you and raise an invoice for you to pay, reimbursement from your network should then be sought.

**BILLING DETAILS:**

|  |  |  |  |
| --- | --- | --- | --- |
| ***PROVIDE BILLING DETAILS FOR THE INDIVIDUAL OR ORGANISATION PAYING INVOICE*** | | | |
| **BILL TO: ☐Individual ☐Organisation** | | | |
| **INDIVIDUAL/STUDENT** | | **ORGANISATION (for non SA health workplaces)** | |
| **PREFIX**  ***(ie: Mr, Ms)*** |  | **NAME OF BUSINESS** |  |
| **BILLING NAME** |  | **CONTACT PERSON** |  |
| **ADDRESS** |  | **ADDRESS** |  |
| **SUBURB** |  | **SUBURB** |  |
| **STATE** |  | **STATE** |  |
| **POSTCODE** |  | **POSTCODE** |  |
| **MOBILE** |  | **MOBILE** |  |
| **PHONE** |  | **PHONE** |  |
| **EMAIL** |  | **EMAIL** |  |

***Cancellations received before 18th April 2018 will be refunded less an administration fee of $50.00.***

***Cancellations made after this date will not be eligible for a refund, although enrolments are transferable.***

**JOURNAL TRANSFER AUTHORISATION FORM**

***You are only required to complete this section if you are an SA Health employee and your organisation is paying for the course.***

***Name of SA Health/Intra Health or Sub-region:***

**☐** WCHN Journal (for WCHN employees) **☐** Journal between SA Health Units

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PARTICIPANT’S NAME** | | | **DESCRIPTION OF COURSE** | | | | | **TOTAL COST (gst excl)** | |
|  | | |  | | | | | $ | |
|  | | |  | | | | | $ | |
|  | | |  | | | | | $ | |
|  | | |  | | | | | $ | |
|  | | |  | | | | | $ | |
|  | | |  | | | | | $ | |
|  | | |  | | | | | $ | |
| This is not an invoice. Charge will be done via journal transfer. Please authorise, fill in the cost centre details, then return for processing to:  **Helen Mayo House, either by**  **Fax: (08)70871060 or**  **Email:** [Health.PIMHSHelenMayoHouse@sa.gov.au](mailto:Health.PIMHSHelenMayoHouse@sa.gov.au) | | | | | | **Sub-Total** | | $ | |
| **GST** | | $ | |
| **Total** | | $ | |
| **Authorisation to Debit Cost Centre**  **Old Centre No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | |
| **LEGACY COST CENTRE** | **BUSINESS** | **UNIT** | | **SERVICE** | **COST CENTRE** | | **PROJECT ID** | **ACCOUNT** | **AMOUNT $** |
|  |  |  | |  |  | |  |  |  |

I authorise WCHN to **Debit** the above Oracle RI for the charge noted above.

Authorised Name:

Authorised Signature:

Position Title:

Department/Division: