CONNECTING HEALTHCARE AND AVIATION – HUMAN FACTORS TRAINING

**This Invoice form is for Participants External to EMHS staff Only.**

* **Please print clearly and complete the application sections in full, as directed.**
* **Once completed email this form to** [**RPBG.NEXUS@health.wa.gov.au**](mailto:RPBG.NEXUS@health.wa.gov.au), **this needs to be sent BEFORE training session**
* **Payment must be made via the invoice mailed to you by Health Support Services, this will be processed post training.**
* **No-shows or late cancellations not advised on the day of the course will still be liable for course fee.**

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| 1. **APPLICANT DETAILS – Please print clearly. Incomplete or ineligible forms will be returned to the applicant.** | | | | | | | | | |
| **Surname:** | | | | | | | | | |
| **First name:** **Preferred name:** | | | | | | | | | |
| Mobile: Work: | | | | | | | | | |
| **Emai**l ***(must be supplied)****:* | | | | | | | | | |
| Position: Ward/Department: | | | | | | | | | |
| Work Location Campus: Choose an item. | | | | If other: | | | | | |
| **B. COURSE DETAILS** – **Please print clearly. Incomplete forms will not be processed.** | | | | | | | | | |
| Course title:  **NEXUS HUMAN FACTORS TRAINING** | | | | | | | | | |
| **Date/s: *Please add the dates you wish to attend the courses: The NEXUS Program consists of three levels, to be completed sequentially, whereby each level is built upon the previous (1>2>3).*** | | | | | | | | | |
| **Site:** Choose an item. | | | | | | | | | |
| **Full Day (1 & 2) 8am-4:30pm**  Click or tap to enter a date. | | **Level 1 (8am-12pm)**  Click or tap to enter a date. | | | **Level 2 (8am – 12pm)**  Click or tap to enter a date. | | | **Level 3 (8am-12pm)**  Click or tap to enter a date. | |
| **Cost: $395 per level inc GST Total cost: $**Choose an item. | | | | | | | | | |
| **Payee responsible**:  Choose an item. | | | | | | | | | |
| **Employee’s address: (*must complete*) *Name and Postal Address:*** | | | | | | | | | |
|  | | | | | | | | | |
| **Payment details:** □ Invoice □ Internal Journal Transfer between public hospitals | | | | | | | | | |
| **Employer’s address:** (***if employer paying course fees***) ***Contact Name and Full Postal address****:* | | | | | | | | | |
|  | | | | | | | | | |
| **C. COURSE PAYMENT AUTHORISATION - IF VIA JOURNAL TRANSFER – (Manager use only)** | | | | | | | | | |
| Amount | Entity Number | | Cost Centre | | | Account Number | | | Fund Number |
| $ |  | |  | | |  | | |  |
| Name of cost centre approving officer: | | | | | | | | | |
| Signature: | | | | | | | Date: | | |