



STUDENT REGISTRATION FORM

Please return completed form to:
 Fiona O'Toole
 Clinical Nurse Educator
 PO Box 200, Corryong, VIC, 3707
 fionao@umhcs.vic.gov.au
 (02) 60 763269

Student details					
Title		Surname		Given Name/s	
Street					
Suburb		State		Post code	
Mobile phone			Home phone		
Email					
Date of birth		Gender			
Emergency contact name		Phone		Relationship	
Medical conditions		<i>Indicate any medical conditions that may impact upon your work (physical conditions, allergies, etc.)</i>			
Discipline			Year level		
Course					
Have you previously undertaken a placement at this health service?		Yes / No		If yes, when?	
Education provider details					
Institution					
Institution address					
Education provider placement coordinator details					
Name					
Phone number		Email			
Placement details					
Supervisor name			Phone (ext.)		
Placement start date		Completion date			
Total placement days					
Learning agreement developed and signed		Yes / No			
Placement statutory requirements					
Has a National Police Records Check been obtained? Yes / No					
Current police check sighted by (health service staff member):					
Has a current Working with Children Check been obtained? Yes / No					
Current Working with Children Check sighted by (health service staff member):					
Certification of applicant					
I hereby certify that the above information is correct and complete to the best of my knowledge and belief. I understand that I may be suspended from placement if any of the statements in this application are found to be deliberately misleading.					
Applicant Name (please print)					
Signature					
Date					
Supervisor signature					
Supervisor name (please print)					
Signature					
Date					

This margin is for binding only. Please do not write in here.

FORM NAME