



# Student Enrolment Form

Health Schools Australia

P.O. Box 815  
Helensvale Qld. 4212  
Ph: (07) 55308899  
Fax: (07) 55308877

<b>Name of Course:</b>		<b>Course No:</b>
<b>Date:</b>		
<b>Electives Chosen:</b>		

Please attach two recent passport photos for ID card
--

## COMPLETE ALL SECTIONS IN FULL

Please use **BLOCK** letters

### Student details

Family Name:

Given Name/s:

**Note:** Your results/qualifications will be issued in the name recorded above

Male:  Female:  Date of Birth:

Residential Address:

Post Code:

Postal Address:

(please state 'as above' if same)

Post Code:

Telephone Contact

Home No:

Work No:

Mobile No:

Email address:

### Cultural Background

Were you born in Australia? Yes  No

If no, which country?

Are you of Aboriginal/Torres Strait Islander origin? Yes  No

Are you currently enrolled with HSA?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you a Graduate of HSA?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you wish to join a local study group?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you applying for Centerlink Payments?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

### Course Details

Course you wish to study:

### How did you become aware of this Course? (Please tick appropriate box)

Radio/TV     Magazine     Family/Friend (Name) \_\_\_\_\_

ATMS     Yellow Pages     Other (Please indicate) \_\_\_\_\_

*Please turn over*



# Student Enrolment Form

## Disabilities

(Answering these questions will not affect your enrolment)

Do you have a disability, impairment or long term medical condition, which may affect your studies?

Yes  No

If you have a disability, please indicate your impairment or long term medical condition by placing a tick in the box below

- |                                 |                          |                             |                          |
|---------------------------------|--------------------------|-----------------------------|--------------------------|
| Back Injury                     | <input type="checkbox"/> | Mobility Impairment- Other  | <input type="checkbox"/> |
| Impaired Function of Arms/Hands | <input type="checkbox"/> | Neurological Condition      | <input type="checkbox"/> |
| Impaired Hearing                | <input type="checkbox"/> | Psychiatric Condition       | <input type="checkbox"/> |
| Impaired Vision - Low Vision    | <input type="checkbox"/> | Speech Impairment           | <input type="checkbox"/> |
| Learning Disability             | <input type="checkbox"/> | Long Term Medical Condition | <input type="checkbox"/> |

Do you require support services, equipment and/or facilities, which may assist you to complete your training? Yes  No

## Schooling

What is your highest COMPLETED school level?

Year 12  Year 10

Year 11  Year 9 or lower

What year did you complete this level?     /     /

## Prior Achievements

Since leaving school have you COMPLETED any qualifications? Yes  No

(If yes, tick applicable boxes)

- |                                |                          |
|--------------------------------|--------------------------|
| Trade Certificate              | <input type="checkbox"/> |
| Advanced/Technical Certificate | <input type="checkbox"/> |
| Other Certificate              | <input type="checkbox"/> |
| Associate Diploma              | <input type="checkbox"/> |
| Undergraduate Diploma          | <input type="checkbox"/> |
| Degree or Postgraduate Diploma | <input type="checkbox"/> |

**DO you wish to apply for Recognition of Prior Learning (RPL)?** Yes  No

**Are you a Licensed Health Care Provider?** Yes  No

If Yes, please provide ABN \_\_\_\_\_  
& Professional Association # \_\_\_\_\_

## Language

What language do you mainly speak at home?

English  Other (please specify) \_\_\_\_\_

Is English Language assistance required?

Yes  No



## Student Enrolment Form

### Payment Plan

Full Fee

Deposit and Instalments

Yearly Fee

Individual Subjects

*Please complete and attach the **Registration***

***Payment Form** to this enrolment*

### Disclosure

Under certain circumstances, Health Schools Australia is bound by law to disclose enrolment details for the purposes mentioned in the Queensland, Training and Employment Act 2000.

### STUDENT DECLARATION

**(Please read carefully)**

- ◆ Enrolment will be valid for a period of 12 months from the date processed.
- ◆ If under 18 years, this form must be signed by a parent/guardian.
- ◆ I agree to abide by the Rules and Regulations and Health Schools Australia Policies (refer to student handbook) and acknowledge that facilities made available for my use will be used only in accordance with the principles of proper use and relevant rules.
- ◆ I confirm the accuracy of the information provided
- ◆ Whilst every endeavour will be made to conduct all advertised courses, Health Schools Australia reserves the right to change timetables, courses offered, teachers and other such details beyond our control that affect enrolments. Health Schools Australia will advise students of any changes made. The details in this document are correct at the time of printing.
- ◆ I acknowledge the materials supplied by Health Schools Australia are protected by international copyright laws.
- ◆ I understand that the materials should not be reproduced or altered without the permission of Health Schools Australia.
- ◆ I agree that Health Schools Australia may disclose my private and/or personal information for the purposes mentioned in the Disclosure above.

### STUDENT SIGNATURE

---

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



## REGISTRATION PAYMENT FORM

### STUDENT DETAILS

- I am a new student       I am a current student but need my details updated  
 I am a past student       I am a graduate of Health Schools Australia (H. S. A)

MR / MRS / MS \_\_\_\_\_ GIVEN NAMES \_\_\_\_\_

SURNAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

Are you a Licensed Health Care Provider?  Yes  No. If yes, please provide:

ABN: \_\_\_\_\_ Professional Association #: \_\_\_\_\_

### COURSE DETAILS

NAME & CODE OF COURSE YOU ARE ENROLLING IN:

### PAYMENT PLAN (*Refer Fee Schedule for course fees*)

Full Fee Payment Plan \$ \_\_\_\_\_

Yearly Fee Payment Plan \$ \_\_\_\_\_

(NB: The Yearly Fee payment is due on the same date as your enrolment date each year until your course is fully paid.)

Deposit and Instalments Payment Plan      Deposit \$ \_\_\_\_\_

(NB: The Monthly Instalment payment is due on the same date each month as the date of your enrolment, with the first instalment due the month after the deposit payment.)

Individual Subjects Payment Plan      Enrolment Fee \$ \_\_\_\_\_

Subject Fee \$ \_\_\_\_\_

**TOTAL AMOUNT PAYABLE (INITIAL) \$ \_\_\_\_\_**

(Refer **INITIAL PAYMENT** overleaf to make your payment for this amount)

H. S. A. will use the information provided here to establish your Student & Account record.  
If you have any queries regarding payments, email [accounts@healthaustralia.com](mailto:accounts@healthaustralia.com)

**Mail to: Health Schools Australia, PO Box 815, Helensvale Qld 4212**  
**(New students, attach this form to your Student Enrolment Record Form)**



# REGISTRATION PAYMENT FORM

## INITIAL PAYMENT

I wish to enrol in my chosen course of study by making my initial payment of \$\_\_\_\_\_ (from Page 1)

- I enclose cheque/money order made payable to Wellness Schools Australia Pty Ltd
- I request H.S.A. to process this payment against the following credit card:

Card Number

--	--	--	--	--	--	--	--	--	--

Card Type: \_\_\_\_\_ Expiry Date: \_\_\_/\_\_\_

Name on Credit Card \_\_\_\_\_

Signature \_\_\_\_\_

- I will transfer this payment directly into the H.S.A. bank account. (Please enter your full name in the description field so that your payment can be correctly identified and receipted against your account).

### Bank Account Details

Bank	National Australia Bank
Branch	Runaway Bay, Qld
BSB	084 913
Account Name	Wellness Schools Australia PL
Account Number	790125085
SWIFT Code	NATAAU3303 (for International Bank Transfers)

## ONGOING PAYMENTS

Only complete this section if you selected the Deposit & Instalments Payment Plan.

- Cheque or Money Order**

I, \_\_\_\_\_, will forward my payment of \$\_\_\_\_\_ by cheque/money order made payable to Wellness Schools Australia Pty Ltd.

- Credit Card**

I, \_\_\_\_\_ authorise Health Schools Australia to process a monthly transaction against the credit card listed below for my payment of \$\_\_\_\_\_. I understand that this will continue until I notify Health Schools Australia in writing of my intention to alter my payment method or until the final payment on my course is processed.

Card Number (or, to use the same Credit Card as above tick this box  & sign below)

--	--	--	--	--	--	--	--	--	--

Card Type: \_\_\_\_\_ Expiry Date: \_\_\_/\_\_\_

Name on Credit Card \_\_\_\_\_

Signature \_\_\_\_\_

- Electronic Funds Transfer**

I, \_\_\_\_\_, will transfer my payment of \$\_\_\_\_\_ directly into the H.S.A. bank account.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_