



Student Enrolment Record Form

(FORM : F6.1-3/1)

| | | |
|---|--|------------|
| Name of Course: | | Course No: |
| Date: | | |
| Duration of Training: (No days/No hrs) | | |

Health Schools Australia
P.O. Box 94
Runaway Bay Qld. 4216
Ph: (07) 55308899
Fax: (07) 55308877

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

Daytime No:

Evening 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 Centrelink Payments? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Course Details

Course you wish to study:

Payment Plan

Please complete and attach the **Registration Payment Form** to this enrolment

Deposit and Instalments

Yearly Fee

Individual Subjects

Please turn over



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 Mobility Impairment– Other
- Impaired Function of Arms/Hands Neurological Condition
- Impaired Hearing Psychiatric Condition
- Impaired Vision – Low Vision Speech Impairment
- Learning Disability Long Term Medical Condition

Do you require support services, equipment and/or facilities, which may assist you to complete your training?

Yes No

7. Schooling

What is your highest COMPLETED school level?

Year 12 Year 10
Year 11 Year 9 or lower

In what year did you complete this school level?

/ /

8. Prior Achievements

Since leaving school have you COMPLETED any qualifications? Yes No

(If yes, tick applicable boxes)

- Trade Certificate
- Advanced/Technical Certificate
- Other Certificate
- Associate Diploma
- Undergraduate Diploma
- Degree or Postgraduate Diploma
- Unspecified Prior Educational Achievement

How did you become aware of this Course?

(Please tick appropriate box)

- Radio/TV Family/ Friend
- ATMS Yellow Pages
- Magazine Other

Language

Which language do you mainly speak at home?

English Other, please specify

Is English language assistance required?

Yes No

DO you wish to apply for RPL Yes No

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 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 Enrolment I am a current student but need my details updated

MR / MRS / MS _____ GIVEN NAME _____

SURNAME: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

NAME OF COURSE YOU ARE REGISTERING FOR: _____

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

ABN: _____ Professional Association #: _____

PAYMENT DETAILS:(See Fee Schedule for course fees)

Payment for: RPL Full Fee Deposit Yearly Fee Individual Subject

Payment Amount: \$ _____

I enclose cheque/money order made payable to Wellness Schools Australia Pty Ltd

I request HSA to process this payment against the following credit card:

Card Type: _____ Expiry Date: ___/___ Signature: _____

Card Number:

| | | | | | | | | | | | | | | | | | | | | |
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I will transfer this payment directly into the Wellness Schools account (refer over page for bank details).

ONGOING PAYMENT DETAILS

- If you selected
1. Deposit & Instalments Payment Plan – please nominate one of the options over page;
 2. Yearly Fee Payment Plan – an invoice will be mailed to you when your next payment is due.

Mail to: Health Schools Australia, PO Box 94, Runaway Bay Qld 4216
(New students please attach this form to your Student Enrolment Record Form)

Please turn over

