The Royal Children's Hospital Melbourne
50 Flemington Road
Parkville Victoria 3052 Australia
TELEPHONE +61 3 9345 5522
www.rch.org.au

The Royal Children's Hospital Melbourne

APPLICATION FORM 2020 / 2021
CERTIFICATE OF PAEDIATRIC NUTRITION AND DIETETICS
PLEASE COMPLETE THIS FORM AND RETURN TOGETHER WITH PAYMENT AS SOON AS POSSIBLE TO SECURE YOUR PLACE

NAME:_____

ADDRESS:_____

_____

TELEPHONE:

WORK: _____ **MOBILE:** _____

FAX: _____

EMAIL: _____

QUALIFICATIONS (INCLUDE YEAR COMPLETED)_____

_____

A COPY OF UNIVERSITY QUALIFICATIONS OR APD CERTIFICATE **MUST** BE SENT WITH THIS APPLICATION FORM.

DETAILS OF YOUR WORK EXPERIENCE:

☐ < 1YEAR ☐ 1-3 YEARS ☐ 4-10 YEARS ☐ >10 YEARS

DETAILS OF YOUR PAEDIATRIC WORK EXPERIENCE:

☐ < 1YEAR ☐ 1-3 YEARS ☐ 4-10 YEARS ☐ >10 YEARS

CURRENT PLACE OF WORK:

_____

WORK LOCATION:

☐ MAJOR CITY PAEDIATRIC HOSPITAL ☐ MAJOR CITY HOSPITAL

☐ RURAL HOSPITAL ☐ PRIVATE PRACTICE

☐ COMMUNITY HEALTH SETTING METROPOLITAN ☐ COMMUNITY HEALTH SETTING RURAL

☐ OTHER (PLEASE GIVE DETAILS) _____

COURSE SELECTION (please tick box):

Unit 1 only		**Unit 1 & 2**		**Unit 2 only * (24th-27th May 2021)**	

Please turn over to complete payment details.

PAYMENT OPTIONS

DEPOSIT: $200.00 Unit 1 only (GST INCLUSIVE) ☐

DEPOSIT: $200.00 Unit 2 only (GST INCLUSIVE) **Due ASAP** ☐

DEPOSIT: $400.00 Unit 1 & 2 (GST INCLUSIVE) ☐

UNIT 1 ONLY: $950.00 (GST INCLUSIVE) ☐
(OR MINUS DEPOSIT PAID = $750.00)

UNITS 1 & 2: $ 1800.00 (GST INCLUSIVE) ☐
(OR MINUS DEPOSIT PAID = $1400.00)
(PAYMENT PLAN AVAILABLE. IF REQUIRED PLEASE CONTACT MARY MCPHERSON)

UNIT 2 ONLY: $950.00 (GST INCLUSIVE) ☐

*PLEASE NOTE: UNIT 2 CAN BE UNDERTAKEN WITHOUT COMPLETING UNIT 1 IF YOU HAVE A MINIMUM OF 3 YEARS WORKING IN PAEDIATRICS. OTHERWISE UNIT 1 MUST BE COMPLETED BEFORE UNDERTAKING UNIT 2.

TOTAL: ☐

Please note credit card payments will incur a 1.5% surcharge

☐ **Pay by Cheque**: *Please make payable to "**Royal Children's Hospital**"*

☐ **Pay by Credit Card**: *Please complete details below:*

Card Type: ☐ **Visa** ☐ **Mastercard** **Amount:** $_____

Card Number: - - - - / - - - - / - - - - / - - - -

Expiry Date: - - / - -

Name: (as it appears on card)_____

Signature:_____

Note: *Any cancellations made after payment has been processed will incur a $100 administration fee.*

Send to:
Mary McPherson & Katie O'Brien (please cc both in)
Department of Nutrition & Food Services
Royal Children's Hospital
Flemington Road, Parkville 3052
Phone: (03) 9345 5668
Email: mary.mcpherson@rch.org.au;
Katie.O'Brien@rch.org.au