



# Provider registration form



## Bushfire Recovery Psychological Support Service

### Service provider details

Sole Provider Name:			
ARPRA / AASW Registration No.:			
<b>OR</b>			
Company Name:			
Authorised Representative Name:			
Authorised Representatives Position:			
Registered Business Name:			
Business Address:			
Postal Address (if different):			
Location(s) at which services are:			
ABN:			
Business Telephone:		Mobile Telephone:	
Email Address:			

### Section 2: Payment details (for sessions provided)

Bank:			
BSB:			
Account Number:			
Account Name:			

### Section 3: List details of all authorized delegates who will deliver this program on the behalf of the organisation: (if more than two please provide details over page)

1	Full Name:	
	Address:	
	Discipline:	
2	Full Name:	
	Address:	
	Discipline:	

### Declaration

I verify that all information provided in the above statements is true and correct. I agree to maintain professional indemnity insurance and public liability insurance coverage as required by law.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name:

\_\_\_\_\_  
Name:

Section 3 continued: List details of all authorized delegates who will deliver this program on the behalf of the organisation:

	Full Name:	
	Address:	
	Discipline:	
	Full Name:	
	Address:	
	Discipline:	
	Full Name:	
	Address:	
	Discipline:	
	Full Name:	
	Address:	
	Discipline:	