SERVICE PROVIDER FORM

Service Provider Name: .....

Telephone: ..... Fax No. .....

Contact Persons: 1. .....

Postal Address: .....

.....

Contact Persons: 2. .....

Postal Address: .....

.....

Location Address: .....
(If different from postal address)

.....

INSURANCE COVER DETAILS

Public Liability:

Insurer: .....

Policy No: ..... Expiry Date: .....

Sighted By: .....

Workers Compensation:

Insurer: .....

Policy No: ..... Expiry Date: .....

Sighted By: .....

Professional Indemnity Insurance

Insurer: .....

Policy No: ..... Expiry Date: .....

Sighted By: .....

Are all your staff covered by Professional Indemnity Policy? Yes ☐ No ☐

If not please give details .....

.....

Department of Veterans' Affairs Provider No: .....
(Private Nursing Service Only)

***** PLEASE ATTACH EITHER COPIES OF ABOVE INSURANCES OR CERTIFICATES OF CURRENCY**

I agree the above information is true and correct and that arrangements are based on relevant legislative requirements in the areas of workers' compensation, occupations health and safety, taxation, superannuation and industrial relations.

....

Signed Dated