

DEPARTMENT OF PARAMEDICS/ALLIED HEALTH



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Student Enrolment Form

Admission to Course:		
Course ID:		
Centre ID:		
Course Duration:	Month	Year
Date of Admission	//	

Section 1: Student Details	
1st Name: (Given Name)	
2nd Name: (Middle Name)	
Last Name	
Date of Birth:	
Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Students's Residential Address:	
Suburb/Town/Community:	Pin Code:
Student's Postal Address: (If Different From Above)	



Office Use Only	
Student's Registration: (Please Use Student Master Index)	
Year:	
Enrolment Status:	FullTime <input type="checkbox"/> PartTime <input type="checkbox"/> FTE <input type="checkbox"/>

Section 2 Parent /Guardian Information
If you are an independent Student (living without a Parent or Guardian) Please go straight to Section 5

	Parent / Guardian 1	Parent / Guardian 2
Name		
Relationship with Student		
Phone		
Mobile		
Email		
Residential Address		
Pin Code		

DECLARATION BY THE APPLICANT

I (Name) _____ hereby declare that all the particulars furnished above are complete and correct to the best of my knowledge. I also understand that I will be disqualified if any of the information is found to be wrong at any level.

Place : _____

Signature:

Date: _____

Name:

Note: (It is your responsibility to notify the institution in writing of any changes to the information provided on this enrolment form)