**Enrolment Form**

**ACT Health Work Based Transition to Practice Programme:**

**Clinical Neurophysiology**

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| **Name** |  |
| **E-mail**  |  |
| **Phone No** |  |
| **Postal Address** |  |
| **Supervisor Name** |  |
| **E-mail** |  |
| **Phone No** |  |
| **Postal Address** |  |
| **Your intended start date?** |  |
| **Are you currently working in the field? (If so, how long for?)** |  |
| **Special Requirements** |  |
| **If you are not responsible for your enrolment fees, provide the name, postal address and e-mail address of the responsible person/contact.** |  |

**E-mail to: Neurologytraining@act.gov.au**