

**APPLICATION FORM**

**Director of Clinical Services**

**Seymour Health**



**[Complete the grey sections in the form below]**

Summary Details

|  |  |
| --- | --- |
| Name |  |
| Postal Address |  |
| Mobile |  |
| Confidential Email |  |
| How did they hear about job |  |

Educational Background

|  |  |
| --- | --- |
| Qualification |  |
| University / Institution |  |
| Year Completed |  |

|  |  |
| --- | --- |
| Qualification |  |
| University / Institution |  |
| Year Completed |  |

|  |  |
| --- | --- |
| Qualification |  |
| University / Institution |  |
| Year Completed |  |

Most recent professional experience

|  |  |
| --- | --- |
| Organisation |  |
| Title |  |
| Reported to |  |
| Dates |  |
| Budget Responsibility |  |
| Staff Reports |  |

|  |  |
| --- | --- |
| Organisation |  |
| Title |  |
| Reported to |  |
| Dates |  |
| Budget Responsibility |  |
| Staff Reports |  |

|  |  |
| --- | --- |
| Organisation |  |
| Title |  |
| Reported to |  |
| Dates |  |
| Budget Responsibility |  |
| Staff Reports |  |

Professional Registration/ Memberships

|  |  |
| --- | --- |
| Professional body |  |
| Registration /Membership Type |  |
| Registration /Membership Number |  |

|  |  |
| --- | --- |
| Professional body |  |
| Registration /Membership Type |  |
| Registration /Membership Number |  |

Pre-Requisite Selection Criteria

|  |  |
| --- | --- |
| APHRA Registration Number | ? |
| Relevant Tertiary Qualifications | Yes / No |
| Current Driver’s License | Yes / No |
| Current Police Check | Yes / No |
| Current Working with Children’s Check | Yes / No / NA |