Health Reimagined

Value Healthy Outcomes

WAHA Application Checklist

Name	
Discipline	
Contact Details	Address: Landline Phone: Mobile Phone: Fax Number: Email Address:
ABN	

Please confirm you have certified evidence of the following:	
Professional Qualification *e.g. Tertiary Qualification*	☐ Yes ☐ No Comments:
Clinical Experience *e.g. current curriculum vitae*	☐ Yes ☐ No Comments:
Current and ongoing professional registration If appropriate	☐ Yes ☐ No Comments:
Police Check	☐ Yes ☐ No Comments:
Hold current professional indemnity and public liability insurances *e.g. Certificate of Currency*	☐ Yes ☐ No Hold current professional indemnity (10 Million) and public liability insurance ($10 Million) or ability to obtain (it is recommended public liability insurance is $20 Million in order to provide services under government funded programs) Comments:
Authorised Sign off	I ______________________________ (name of authorized representative) hereby declare that all of the information provided in this checklist is true and correct and that I have provided certified evidence of the credentials of the abovenamed to Health Regimagined. Signature: ______________________________ Title: ______________________________ Date: ______________________________