APPLICATION VIDEO CONFERENCE

BOOKING INFORMATION

Company/Name____

Participants Name______________________________________

Address____

Suburb____

State & Postcode_______________________________________

Phone Number____

Booking Date____

Booking Time____

Reason for Booking_____________________________________

PAYMENT DETAILS

Connecting Phone No___________________________________

Est Time Required______________________________________

Tailem Bend District Hospital DIAL IN: YES NO

If YES, charges are included on the back of this information brochure.

If NO, a booking fee of $5.00 will apply

Person Responsible for Fee_______________________________

Address____

Suburb____

State & Postcode_______________________________________

USER CONTRACT

DECLARATION

I have read the INFORMATION BROCHURE regarding the use of the Video Conferencing facilities.
I understand the content of the INFORMATION BROCHURE and will abide by these conditions.

Signature__________________________Date________

Please complete both sides of this brochure
& return this section to the
Tailem Bend District Hospital
PO Box 63 Tailem Bend SA 5260 or
Fax (08) 85 725 801