WAITING LIST APPLICATION

Date: ____/____/____

Child's Name: ____ D.O.B.: ____/____/____

Address: ____ _____________PC: _____________

PARENTAL DETAILS		
	MOTHER	**FATHER**
Name		
Address		
D.O.B.		
CRN		
Phone (home)		
Phone (work)		
Place of work		
Occupation		

HOW DID THIS FAMILY COME TO HEAR ABOUT ECHIDNA? ____

Number of days required per week: 1 2 3 4 5

(Please circle)

Actual days required: M Tu W Th F

(Please circle)

If you require less than 5 days are you prepared to accept any days that are available?

- € **Yes** I am prepared to accept any days that are available
- € **No** I specifically require the days I have indicated above

STARTING DATE REQUIRED: ____/____/____ or ASAP

(please insert approximate start date)

PRIORITY OF ACCESS: THESE ANSWERS WILL DETERMINE YOUR PRIORITY OF ACCESS TO CARE

PRIORITY 1		
A child at risk of serious abuse or neglect	YES	NO
PRIORITY 2 If you answer 'YES' to any of the following you are required to provide proof under Section 14 of the Family Assistance Act		
Are you a single parent that is working?	YES	NO
Are you a family with both parents working?	YES	NO
Are you studying for future employment?	YES	NO
Are you seeking employment or training?	YES	NO
PRIORITY 3		
Any other child?	YES	NO

Does your child have additional needs? If 'YES', please specify.

____

I understand the Priority of Access conditions outlined above and agree to notify the Centre should my circumstances change.

Relationship to Child: ______________________________________ Signature: _______________________________

Echidna Children's Centre