

# RURAL HEALTH WEST KIMBERLEY WEEKEND CONFERENCE

## REGISTRATION FORM

Cable Beach Club Resort, Broome

8-10 May 2009

**Post to** Leesa Foote  
Rural Health West  
PO Box 433 Nedlands WA 6909

**Telephone** 08 6389 4538  
**Facsimile** 08 6389 4501  
**Email** events@ruralhealthwest.com.au

Name \_\_\_\_\_ Partner's name \_\_\_\_\_

Children's names and ages \_\_\_\_\_

Practice/organisation \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Special dietary requirements \_\_\_\_\_

### Registration (fees inclusive of GST)

I will be attending the National Prescribing Service Presentation at KDGP followed by dinner at Matso's on Friday 8 May 2009

**Full registration \$150.00**

### Social program (please indicate number of guests attending)

Family dinner \_\_\_\_\_ adults \$30 per person \_\_\_\_\_ children (5-15 years) \$15 per person

### Accommodation

**Rural Health West will book accommodation on your behalf at Cable Beach Club Resort. Credit card payment is required with registration to secure your booking. Accommodation bookings close Friday 1 May 2009 and are subject to availability at time of registration.**

Please indicate below if you require accommodation:

Run of house studio (includes breakfast) \$261/night  
2 adults + one complimentary rollaway bed available for one child

Bungalows are available, however, they must be booked with the resort direct.

Check-in date \_\_\_\_\_ Check-out date \_\_\_\_\_

### Travel

Fuel costs for transport to the conference (when using private vehicle) will be reimbursed if original Tax Invoices/receipts are forwarded to Rural Health West. For scheduled flight bookings, please contact Angela Penberthy at FCm Travel by email [angela.penberthy@fcmtravel.com.au](mailto:angela.penberthy@fcmtravel.com.au)

If suitable scheduled flights are unavailable, a charter flight will be arranged. Please tick this box and you will be contacted on receipt of registration.

### Payment details

**GRAND TOTAL \$ \_\_\_\_\_**

Cheque enclosed (payable to Rural Health West) OR please debit my

Visa / Mastercard (please circle)

Expiry Date \_\_\_\_ / \_\_\_\_ Name on card \_\_\_\_\_

Cardholder's signature \_\_\_\_\_