# Nomination of booking staff

By signing this form I, *(insert title and full name of practitioner)*, acknowledge and confirm that:

1. The following information is accurate and represents all staff at each practice location who are responsible for the booking of patient appointments.
2. The nomination of each staff member is accompanied by acknowledgement from each nominated staff member, on the approved form, that they are aware the Office of the Health Ombudsman may contact them and exchange information.

## Nominees’ details

|  |  |
| --- | --- |
| Nominee 1 | |
| Full name: | *(Insert full name of nominee)* |
| Registration number (if registered): | *(Insert registration number)* |
| Place of practice: | *(Insert company name)* |
| Postal address: | *(Insert postal address)* |
| Phone number/s: | *(Insert phone number/s)* |
| Email address: | *(Insert email address)* |

|  |  |
| --- | --- |
| Nominee 2 | |
| Full name: | *(Insert full name of nominee)* |
| Registration number (if registered): | *(Insert registration number)* |
| Place of practice: | *(Insert company name)* |
| Postal address: | *(Insert postal address)* |
| Phone number/s: | *(Insert phone number/s)* |
| Email address: | *(Insert email address)* |

Practitioner’s signature: Date: *Click here to enter a date.*

## Nominees’ details (continued)

|  |  |
| --- | --- |
| Nominee 3 | |
| Full name: | *(Insert full name of nominee)* |
| Registration number (if registered): | *(Insert registration number)* |
| Place of practice: | *(Insert company name)* |
| Postal address: | *(Insert postal address)* |
| Phone number/s: | *(Insert phone number/s)* |
| Email address: | *(Insert email address)* |

|  |  |
| --- | --- |
| Nominee 4 | |
| Full name: | *(Insert full name of nominee)* |
| Registration number (if registered): | *(Insert registration number)* |
| Place of practice: | *(Insert company name)* |
| Postal address: | *(Insert postal address)* |
| Phone number/s: | *(Insert phone number/s)* |
| Email address: | *(Insert email address)* |

Practitioner’s signature: Date: *Click here to enter a date.*

Please return this form to the Office of the Health Ombudsman.