Organisation:

As the authorised signatory on the Rural Health West Service Provider Agreement for outreach health services. I agree that the names and email addresses listed below are to be established as delegated users of the Outreach Management System on behalf of this organisation.

In the instance that details of an approved delegated user of the Outreach Management System change, or are no longer current, I understand it is our organisation’s responsibility to notify Rural Health West in writing with details of the change.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| User | Title | First Name  | Surname | Gender | Email address | Position  |
| 1 |       |       |       |       |       |       |
| 2 |       |       |       |       |       |       |
| **Nominted finance email address - this address will receive automated invoices upon entry of a Service Activity Report following a visit.** |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** |  | **Signature:** |  | **Date:** |  |