

Committee Name:

G.S.T. Registered YES NO *(Please tick)* **ABN:**..... **Zone:**.....

Secretary Name **Telephone***

Secretary's Name and Telephone* number are printed on the date list published in the magazine and on the website.

Address **P.C.**

Telephone **Fax** **Mobile**

Email

President Name **Telephone**

Address **P.C.**

Telephone **Fax** **Mobile**

Email

Treasurer Name **Telephone** **Email**

Date Requested

Event Description (ie Training, Team Penning, Meeting/Working Bee)

Accurate estimate of the number of participants

(For the following section please refer to the first aid requirements in this package)

Type of and distance to nearest emergency medical care facility

Type of medical intervention to be used

The effective method of communication for contacting emergency services

Please attach a copy of the qualifications of the person that will act on the day

Please advise if event is cancelled or postponed as Public Liability Insurance Day Fees are transferable