

**HEALTH SCIENCES LIBRARY
 RMH, RWH, PMCC and Victorian Mental Health
 CLIENT REGISTRATION FORM**

Phone: 9342 8617 Fax : 9342 8615

PERSONAL DETAILS

Title: Prof/Dr/Mr/Mrs/Ms/Miss
 Surname: _____ Given Names: _____
 Position: _____

EMPLOYMENT DETAILS

Dept/Ward: _____
 Place of Work (PLEASE CIRCLE): RMH-City RMH-Royal Park RWH PMCC
 Work phone (LANDLINE PLEASE): _____ AND / OR Pager: _____
 Preferred E-mail address: _____

Will you be at this placement/employment for less than 1 year? No Yes If yes, give last date: ____ / ____ / ____

***** RESIDENTIAL DETAILS (all registrants to complete)**

Home Street Address: _____
 Suburb: _____ Post Code: _____ Home Phone/Mobile: _____

*** Please Note: All personal information provided to the Library is kept confidential.

COURSE DETAILS (if applicable)

Students: Graduate Certificate Nursing (ACU) – RMH Staff Stream: _____
 Graduate Certificate Nursing (ACU) – Melbourne Private Staff Stream: _____
 Medical 2nd Year 3rd Year 4th Year Scholarly Selective
 Allied Health Pharmacy Other _____ Supervisor: _____

CONDITIONS OF MEMBERSHIP

I agree:	To return loans by due date(s). I understand that services will be suspended or limited on default, and fines levied for the overdue period. To replace library materials lost or damaged while on loan to me (cost of item plus \$35 admin fee) That any passwords supplied to me by the Library are for my personal use and are not to be shared or otherwise distributed to others (even other registered Library Members), as this is a violation of the contract agreement between RMH Library and its supplying vendors.
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SIGNATURE: _____ Date: ____ / ____ / ____

Library use only:		Barcode No.:	_____	Monitor Entry:	<input type="checkbox"/>	Passwords:	<input type="checkbox"/>
ADMIN	DR	MED4	PHARM	TECH			
ALLD	HMO	MISC	RES	UNIV			
AMS	HON	MPGCN	RMGCN	VIDRL			
ASTUM	MED2	NB	RN				
CORP	MED3	NE	SCIE	OTHER			