**Returnable Schedule 1**

|  |  |
| --- | --- |
| **Contract Number:** | SBRCEOI - 20/21-01 |
| **Description of Goods/Services** | Provision of Health Care Services for Council |

**Respondent Details**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Legal Company Name:** | | | | |  | | | | | | | | | | | |
| *If legal name is a trust, indicate Trustee for the trust. This must be an individual name or Pty Ltd company.* | | | | | | | | | | | | | | | | |
| **Register Trading Name:** | | | | |  | | | | | | | | | | | |
| *(as appears on invoice)* | | | | | | | | | | | | | | | | |
| **ACN (if applicable):** | | |  | | | | | | | | | | | | | |
| **ABN (if applicable):** | | |  | | | | | | | | | | | | | |
| **Street Address:** | |  | | | | | | | | | | | | | | |
| **Suburb:** | |  | | | | | | | | | | | | **Postcode:** | |  |
| **Postal Address:** | |  | | | | | | | | | | | | | | |
| **Suburb:** | |  | | | | | | | | | | | | **Postcode:** | |  |
| **Telephone:** |  | | | | | | | | | **Mobile:** | |  | | | | |
| **Facsimile:** |  | | | | | | | | | **Email:** |  | | | | | |
| **Website:** |  | | | | | | | | | | | | | | | |
| **Contact Name for Respondent:** | | | | | |  | | | | | | | | | | |
| *I am the duly authorised delegate of the company listed in the registered trading name of this form with the delegated power to issue this document on behalf of the Legal Company Name.* | | | | | | | | | | | | | | | | |
| **Contact Name for Respondent:** | | | | | | | | |  | | | | | | | |
| **Contact Name for Accounts enquiries:** | | | | | | | | |  | | | | | | | |
| **Contact Name for Contract Management:** | | | | | | | | |  | | | | | | | |
| **~~Tendered Price~~ *~~(amount excluding GST)~~*~~:~~** | | | | | | | | NOT APPLICABLE | | | | | | | | |
| *~~(If applicable)~~* | | | | | | | | | | | | | | | | |
| **Authorised Signatory’s Full Name:** | | | | | | |  | | | | | | | | | |
| **Authorised Signatory’s Signature:** | | | | | | |  | | | | | | | | | |
| **Witness’ Full Name:** | | | |  | | | | | | | | | | | | |
| **Witness’ Signature:** | | | |  | | | | | | | | | **Date:** | |  | |

**~~Returnable Schedule 2~~**

**~~Pricing Schedule~~**

**Not Applicable**

**Returnable Schedule 3**

**Insurance**

The Respondent must provide a completed schedule of Insurances.

| **Public Liability Insurance - Minimum coverage of $20,000,000** | |
| --- | --- |
| **Policy Number:** | <<Provide details>> |
| **Name of Insurer:** | <<Provide details>> |
| **Named Insured:** | <<Provide details>> |
| **Sum Insured:** | <<Provide details>> |
| **Expiry date:** | <<Provide details>>  **NOTE:** Specify any exclusions and deductibles to the above Insurance Policy. |

| **Individual Medical / Professional Indemnity Insurance** | |
| --- | --- |
| **Policy Number:** | <<Provide details>> |
| **Name of Insurer:** | <<Provide details>> |
| **Named Insured:** | <<Provide details>> |
| **Sum Insured:** | <<Provide details>> |
| **Expiry Date:** | <<Provide details>>  **NOTE:** Specify any exclusions and deductibles to the above Insurance Policy. |

|  |  |
| --- | --- |
| **Australian Health Practitioner Regulation Agency Number:** | <<Provide details>> |

**~~Returnable Schedule 4~~**

**~~Additional information~~**

Not Applicable