New Employee Personal D		Western Health 💔				
Print Save As Submit						
Form Completing this form allows People and Culture to complete on-boarding and create an employee profile in our payroll Information: system.						
Approval Path: Employee > People & Culture						
Submit form to:Recruitment TeamCopy to:Employee		People & Culture Contact: 03 8345 6689				
Copy to: Employee Policy Link / Procedure - Guide Link		Updated: July 2023				
SECTION 1 – EMPLOYEE DETAILS						
Legal First Name	Middle Names		Legal Last Name			
Preferred First Name	Gender		Date of Birth			
Start Date	Position		Area/Department			
SECTION 2 – RESIDENTIAL ADDRE	SS					
Address						
Suburb		Postcode				
Personal Email Address		Contact Number				
SECTION 2 – MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRI	= 2 2 1					
Address	_33/					
Suburb		Postcode				
State		Country				
SECTION 4 – EMERGENCY CONTACT DETAILS (PLEASE COMPLETE DETAILS OF WHO WE MAY CONTACT IN AN EMERGENCY)						
(PLEASE COMPLETE DETAILS OF WHO WE MAY CONTACT IN AN EMERGENCY) Name						
Contact Number		Relationship				
		neialioneilip				



SECTION 5 – EQUITY, DIVERSITY & INCLUSION					
One of our goals at Western Health is to enhance diversity, equity, inclusion, and belonging. Demographics are key to examining the experiences that our employees with different backgrounds and personal identities have, which is why we are interested in collecting this information. You are not required to provide this information. If you choose to provide it, we will securely store in on your payroll profile. This data will be de-identified when used for reporting purposes, e.g. Workforce Gender Equity indicators.					
I his data will be de-identified when used for reporting pur					
	пус	ou spear	a second lar	nguage please specify?	
<ul> <li>Strait Islander origin?</li> <li>Aboriginal</li> <li>Torres Strait Islander</li> <li>Both Aboriginal &amp; Torres Strait Islander</li> <li>Not Aboriginal or Torres Strait Islander</li> <li>Prefer not to answer</li> </ul>		Country of Birth			
		Do you identify as a person with a disability?			
		Yes	🗌 No	Prefer not to answer	
		If yes, do you require a work adjustment?			
		Yes	🗌 No		
SECTION 6 – SUPERANNUATION DETAILS	. (				
Employees must nominate either one of our industry funds (Aware super or HESTA) by ticking the preferred box below, or must nominate an alternative fund by completing the superannuation standard choice form					
Superfund Name		Membe	rship Number	r (if known)	
Aware Super					
HESTA or Other (Please complete the Superannuation Standard Choice form)					
Defined Benefit (Please attach relevant documentation)					
SECTION 7 – BANK ACCOUNT DETAILS					
Main Bank Account (where your net pay will be deposited unless	additio	nal accoun	ts are specified)		
Bank Name (e.g. Commonwealth, ANZ, etc.):					
BSB Number (Branch No: must be 6 digits)**:					
Account Number**:					
Account Name:					
Account 2 (to be completed if you wish to set an amount per pay into	anoth	er account)	)		
Split payments to this account					
Amount to be deposited per pay period or percentage:		\$		%	
Bank Name (e.g. Commonwealth, ANZ, etc.):					
BSB Number (Branch No: must be 6 digits):					
Account Number:					
Account Name:					
Account 3 (to be completed if you wish to have a 2 <sup>nd</sup> set amount per	pay int	o another a	account)		
Split payments to this account					
Amount to be deposited per pay period (or percentage:		\$		%	
Bank Name (e.g. Commonwealth, ANZ, etc.):					
Account Name:					
Account Number:					
BSB Number (Branch No: must be 6 digits):					

## Western Health

## SECTION 8 – EMPLOYEE AGREEMENT

Employee Signature

Date

## SECTION 9 – WESTERN HEALTH FOUNDATION DONATION EMPLOYEE AGREEMENT

## Small change creates big change!

Join our workplace giving program to provide a stronger health service for Western Health's patients and staff



This is not mandatory. Please tick if you would like to make a pre-tax donation.

Yes, I'd like to make a difference and become a member of the workplace giving program to have a greater impact in supporting the work of the Western Health Foundation. Please deduct the following amount each pay period;

□\$2

□ \$5

□\$10

Other \$\_\_\_\_

I acknowledge that by opting into this program, I consent to make pre-tax payroll deduction each pay to support the work of the Western Health Foundation. I understand that deductions will be taken from my gross salary and I will be paying a reduced amount of tax on my salary. I acknowledge that this will all be reflected on my income statement. I consent to receiving information about my donation and the ongoing work of the Western Health Foundation.

Employee Signature	Date