



## Supporting Children with Additional Needs (SCAN) Program

### Service Profile Form

#### Service Details

Service Name:					
Address:					
Mailing address (if different):					
Phone:			Fax:		
Email:					
ABN Number:			Registered for GST    yes <input type="checkbox"/> no <input type="checkbox"/>		
Name of Authorised Supervisor:					
Licensed Number of Places:					
Days and hours of operation					
	Monday	Tuesday	Wednesday	Thursday	Friday
AM					
PM					
Weeks of operation	Term 1	Term 2	Term 3	Term 4	
Start date					
End date					
No. weeks per term					

#### Account Details

Name of financial institution	
Branch address	
Account name	
Account number	
BSB number	

**Certification (This section must be signed by two members of the Management Committee)**

On behalf of the Management Committee we certify all information provided on this form is correct

Print Name \_\_\_\_\_

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Position \_\_\_\_\_

Position \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_