



# BOOKING FORM

AFFILIATE CLINICS

### More Information :

Level 3, 72 Melville Parade,  
South Perth, WA 6151

(08) 9259 0600

www.knighthealth.com.au

Please email completed request to:  
affiliates@knighthealth.com.au

TO BE TYPE-WRITTEN ONLY. HANDWRITTEN REQUESTS WILL NOT BE ACCEPTED.

Debtor Name:

Client ID:

### APPOINTMENT REQUEST : Please provide 3 preferred dates and times

Date:	<input type="text"/>	Time:	<input type="text"/>
Date:	<input type="text"/>	Time:	<input type="text"/>
Date:	<input type="text"/>	Time:	<input type="text"/>

If you have another preferred location, please specify:

Preferred Location 1:	<input type="text"/>
Preferred Location 2:	<input type="text"/>

### ASSESSMENTS REQUIRED

MEDICAL

Knight Health Medical

Client-specific Medical :

Paperwork attached

Industry-specific Medical :

Paperwork attached

ADDITIONAL REQUESTS

#### AUDIOMETRY:

- Standard
- Regulatory

#### SPIROMETRY:

- Spirometry

#### DRUG / ALCOHOL SCREENING:

(select one or both)

- Lab Drug and Alcohol
- Instant Drug and Alcohol

#### MUSCULOSKELETAL / FITNESS

(select as required)

- Musculoskeletal
- Fitness
- Chester Step Fitness

#### FUNCTIONAL CAPACITY EVALUATION

(please provide client-specific paperwork)

- Low
- Medium
- High

#### PATHOLOGY BLOODS / X-RAY / ECG

(select all that is required)

- Resting ECG
- Chest X-Ray
- Lipids
- HbA1c
- Other:

#### RESPIRATOR / EAR FIT TESTING

- Ear Plug Fit
- Respirator Fit

\* Type of mask required:

ADDITIONAL ASSESSMENTS:

### CANDIDATE DETAILS

Name:  Date Of Birth:  Gender:

Proposed Role:  Contact No:  Site:

Email:

### BOOKING OFFICER DETAILS

Name:  Contact No:

Email:

Additional Booking Information:

### INVOICING DETAILS

Purchase Order:  Cost Code:

Requesting Person:  Site: