

Health Support Services
Human Resources
Fax (08) 6444 5899

D8

SOCIAL CLUB DEDUCTION FORM

000009287

C DEDUCTION DETAILS Employee Name:	Please complete this form using a BLACK PEN and BLOCK CAPITALS. * Denotes a mandatory field. Forward to HSS Payroll by FAX . Note: This printable version of the form must not be emailed.			
(B) CURRENT DETAILS: 'Employee Number: 'Given Name(s): "Department: M E D I C A L D O C T O R (C) DEDUCTION DETAILS: Employee Name: I, Employee Name: Hereby authorize F I O N A S T A N L E Y H O S P I T A L Health Service/Region: To deduct \$ 12.00 per pay period, from my wages, starting pay period ending Reason: for R M O A S S O C F E E (F S H) STANLEY MEDICAL OFFICERS SOCIETY Social Club. I reserve the right to revoke this payroll deduction authorisation at any time.	(A) HEALTH SERVICE / AGENCY: * Site Abbreviation:			
*Employee Number:	FIONA STANLEY HOSPITAL			
*Given Name(s): "Department: M E D I C A L D O C T O R C DEDUCTION DETAILS:	(B) CURRENT DETAILS:			
*Department: M	*Employee Number: *Family Name:			
*Department: M				
M E D I C A L D O C T O R	*Given Name(s):			
M E D I C A L D O C T O R				
(C) DEDUCTION DETAILS: Employee Name: I, Employer Name: hereby authorize F I O N A S T A N L E Y H O S P I T A L Health Service/Region: To deduct \$ 12.00 per pay period, from my wages, starting pay period ending Reason: for R M O A S S O C F E E (F S H) STANLEY MEDICAL OFFICERS SOCIETY Social Club. I reserve the right to revoke this payroll deduction authorisation at any time.				
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Employee Name:	(C) DEDUCTION DETAILS:			
Employer Name:				
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Health Service/Region: to deduct \$ 12.00 per pay period, from my wages, starting pay period ending Reason: To Date: Do D M M Y Y Y Y For R M O A S S O C F E E (F S H) STANLEY MEDICAL OFFICERS SOCIETY I reserve the right to revoke this payroll deduction authorisation at any time.	Employer Name:			
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I reserve the right to revoke this payroll deduction authorisation at any time.				
	STANLEY MEDICAL OFFICERS SOCIETY Social Club.			
(D) EMPLOYEE SIGNATURE :	I reserve the right to revoke this payroll deduction authorisation at any time.			
(D) EMPLOYEE SIGNATURE:	(D) EMPLOYEE COMATURE			
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I certify that the above information is correct.	·			
*Employee Name: *Telephone/Ext: *Signature: *Date:				

Return this form to HSS Payroll as soon as possible to avoid overpayment of salary. FAX to 6444 5899.

*** Note: Always use the most current version of a form from HealthPoint to avoid processing delays.

SOCIAL CLUB DEDUCTION FORM

lealth Service/Agency	Site Abbreviation
RMADALE HEALTH SERVICE	AHS
ENTLEY HEALTH SERVICE	BHS
CHILD AND ADOLESCENT HEALTH SERVICE	CAHS
DENTAL HEALTH SERVICES	DHS
DEPARTMENT OF HEALTH - DIRECTOR GENERAL DIVISION	RSD
OGD HEALTH METRO	DGD
M OFFICE OF THE CHIEF EXECUTIVE	EMHS
TIONA STANLEY HOSPITAL	FSH
REMANTLE HOSPITAL AND HEALTH SERVICE	FHHS
GRAYLANDS HOSPITAL	NMAMHS
HEALTH AND DISABILITY SERVICES COMPLAINTS OFFICE	OHR
HEALTH SUPPORT SERVICES	HHS
MAGING WEST	IMWEST
KALAMUNDA HEALTH SERVICE	KHS
MENTAL HEALTH COMMISSION	МНС
NM OFFICE OF THE CHIEF EXECUTIVE	NMAMHS
PATHWEST LABORATORY MEDICINE WA	PLMWA
PEEL AND ROCKINGHAM KWINANA HEALTH SERVICE	PRKHS
ROYAL PERTH HOSPITAL	RPH
ROYAL PERTH REHABILITATION HOSPITAL	RPH
SELBY LEMNOS GROUP	NMAMHS
SIR CHARLES GAIRDNER AND OSBORNE PARK HOSPITALS	SCGH
SM OFFICE OF THE CHIEF EXECUTIVE	SMAHS
SOUTH METROPOLITAN AREA MENTAL HEALTH SERVICE	SMAMHS
SWANS HEALTH SERVICE	SKHS
WACHS - CENTRAL OFFICE	WACHSAO
NACHS - GOLDFIELDS	WACHSGF
WACHS - GREAT SOUTHERN	WACHSGS
WACHS - KIMBERLEY	WACHSKR
NACHS - MIDWEST	WACHSMW
WACHS - PILBARA	WACHSPR
WACHS - SOUTH WEST	WACHSSW
WACHS - WHEATBELT	WACHSWB
WOMEN AND NEWBORN HEALTH SERVICE	WNHS