If you are a rural doctor, please complete all the information on this form, and send it back to the Rural Support Service (RSS) Clinical Workforce Finance Team via email: Health.RSSClinicalWorkforceFinance@sa.gov.au

# Section A – general information

## Entity

|  |  |
| --- | --- |
| Name: |       |
| Address: |       |
| Phone: |       | Mobile: |       |
| Email: |       |

## Entity registration details

|  |  |  |  |
| --- | --- | --- | --- |
| ABN: |       | ACN: |       |
| Registered for GST | Yes: [ ]  | No: [ ]  |
| Sole trader: [ ]  | Partnership: [ ]  | Trust: [ ]  | Body corporate: [ ]  |
| Registered Business / Trading Name |       |
| If entity is a trust, trust name: |  |
| Trustee name for the trust: |       |

## Representative(s)

|  |  |
| --- | --- |
| Practice name: |       |
| Contact name |       |
| Position: |       |
| Email: |       |
| Phone: |       | Mobile:       |
| Contact person for payment/claim enquiries (if different from above)       |
| Phone: |       | Email:       |
| Who in your practice, other than the Nominated Medical Practitioners outlined below, should receive RSS information and RSS bulletins? You can nominate as many people as you wish.  |
| Name: |       | Direct email:       |
| Name: |       | Direct email:       |

## Department of Veteran Affairs (DVA)

You can submit a claim for DVA patients directly to DVA, however, you can claim for DVA patients through the RSS Clinical Workforce Finance Team. If selected, this will cover all nominated medical practitioners listed.DVA to be paid through RSS Clinical Workforce Finance Team? Yes [ ]  No [ ]

*Please note: if no selection is made, you will need to claim directly to DVA.*

**I am authorised to provide the above information on behalf of the contracted entity.**

|  |  |
| --- | --- |
| **Signature:**  | **Name:**  |
| **Position title:** | **Date:** |

**Hospitals/sites:** Please list all the hospitals */* sites where services will be provided.

|  |
| --- |
|  |

## Nominated Medical Practitioner(s) and their contact details

Please provide the details requested below of all nominated Medical Practitioners.

|  |
| --- |
| **Medical Practitioner 1** |
| Name: |  | AHPRA Number: |  |
| Mobile: |  | Direct email: |  |
| SA Health employee: | Yes: [ ]  No: [ ]  | Full-time: [ ]  Part-time: [ ]  |
| **Medical Practitioner 2** |
| Name: |  | AHPRA Number: |  |
| Mobile: |  | Direct email: |  |
| SA Health employee: | Yes: [ ]  No: [ ]  | Full-time: [ ]  Part-time: [ ]  |

|  |
| --- |
| **Medical Practitioner 3** |
| Name: |  | AHPRA Number: |  |
| Mobile: |  | Direct email: |  |
| SA Health employee: | Yes: [ ]  No: [ ]  | Full-time: [ ]  Part-time: [ ]  |
| **Medical Practitioner 4** |
| Name: |  | AHPRA Number: |  |
| Mobile: |  | Direct email: |  |
| SA Health employee: | Yes: [ ]  No: [ ]  | Full-time: [ ]  Part-time: [ ]  |
| **Medical Practitioner 5** |
| Name: |  | AHPRA Number: |  |
| Mobile: |  | Direct email: |  |
| SA Health employee: | Yes: [ ]  No: [ ]  | Full-time: [ ]  Part-time: [ ]  |
| **Medical Practitioner 6** |
| Name: |  | AHPRA Number: |  |
| Mobile: |  | Direct email: |  |
| SA Health employee: | Yes: [ ]  No: [ ]  | Full-time: [ ]  Part-time: [ ]  |

To add more nominated medical practitioners, please use another copy of this form and enter only the contract entity, name and ABN on the first page.

# Section B - recipient created tax invoice (RCTI) agreement

Please select your relevant regional LHN

|  |  |  |
| --- | --- | --- |
| [ ]  BHFLHN, ABN [51 528 663 451](https://abr.business.gov.au/ABN/View?abn=51528663451) | [ ]  EFNLHN, ABN [34 412 710 120](https://abr.business.gov.au/ABN/View?abn=34412710120) | [ ]  FUNLHN, ABN [53 549 572 794](https://abr.business.gov.au/ABN/View?abn=53549572794) |
| [ ]  LCLHN, ABN [16 739 520 069](https://abr.business.gov.au/ABN/View?abn=16739520069) | [ ]  RMCLHN, ABN [44 685 908 941](https://abr.business.gov.au/ABN/View?abn=44685908941) | [ ]  YNLHN, ABN [11 810 453 593](https://abr.business.gov.au/ABN/View?abn=11810453593) |

The regional LHN will raise a tax invoice on your behalf, please read and sign the declaration and return to the address below.

### Conditions of the Agreement

1. The regional LHN will issue RCTIs to you for all payments for clinical services rendered by you in accordance with your agreement.
2. Please don’t issue any tax invoices in respect to services already supplied.
3. The regional LHN shall issue an adjustment note if required.
4. You are registered for GST purposes at the time of signing the RCTI Agreement and have notified the regional LHN of your Australian Business Number (ABN).
5. Please notify the regional LHN should you cease to be registered for GST purposes or you become aware of any reason that your registration may be cancelled.
6. The regional LHN's ABN (indicated above) is registered for GST purposes.
7. The regional LHN will notify you should it cease to be registered for GST purposes or becomes aware of any reason why its registration may be cancelled or ceases to satisfy any of the requirements of public ruling GSTR 2000/10 or its successors.
8. You are the person authorised to agree to the terms of this Agreement which is legally binding.

### Declaration

I am authorised to agree to the terms of the RCTI Agreement:

|  |  |
| --- | --- |
| **Name:** |       |
| **Position:** |       |
| **Registered entity name:** |       |
| **ABN:** |       |

**Signature:** **Date:**

### *Office use only*

Signed on behalf of:

**Regional LHN:**

**Name:** **Position:**

**Signature: ** **Date:**

# Section C – sole trader superannuation contributions

Please complete this section if you are nominating as a sole trader.

Please provide details of your superannuation fund below. The relevant regional Local Health Network will forward your contributions to that fund. Please read and sign the Sole Trader Superannuation Contribution Declaration on the following page of this form and forward to the address below.

**Please note:** The fund must be a regulated superannuation fund under the Superannuation Industry (Supervision) Act 1993. Superannuation contributions cannot be paid to a Super SA Triple S account but can be paid to a Super SA Select account.

### Personal details

|  |  |
| --- | --- |
| Surname: |       |
| First name: |       |
| Date of birth: |       |
| Tax File Number: |       |

### Super fund details

**I choose for my super to paid into:** (Please select one of the options below and complete all details)

**[ ]  My existing super fund** (not a Self-Managed Super Fund or a Super SA Triple S account)

|  |  |
| --- | --- |
| Name of superannuation fund  |       |
| Superannuation fund ABN |       |
| Membership number |       |
| Unique Superannuation Identifier (USI) |       |
| Your full name as it appears on your account |       |

**[ ]  My regional LHNs default super fund** (HESTA)

[ ]  I want the regional LHN to open a new account for me in their default fund.

**[ ]  My private Self-Managed Super Fund (SMSF)** (\* denotes a mandatory field)

|  |  |
| --- | --- |
| \*Name of superannuation fund  |       |
| \*Superannuation Fund ABN |       |
| \*Electronic Service Address (ESA) |       |
| \*Your full name as it appears on your account |       |
| Fund contact person |       |
| Fund contact phone number |       |
| \*Fund bank account details | Account name: |       |
| BSB:       | Account number:       |

## Additional contributions to superannuation

**I choose for additional contributions to be paid** Yes: [ ]  No: [ ]

If yes, please complete all details below. Salary sacrifice – treated as Reportable Employer Superannuation Contributions. Additional Superannuation Contributions cannot be accepted if you are over 75 years of age.

**What is the percentage of additional contributions to be paid:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| [ ]  10% | [ ]  20% | [ ]  30% | [ ]  40% | [ ]  50% | [ ]  60% | [ ]  70% | [ ]  80% | [ ]  90% | [ ] 100% | Other      %  |

**What regional LHN sites do you want this to be applied to:**

[ ]  I wish to make additional employer contributions at all rural sites where I provide services.

[ ]  I only wish to make additional employer contributions at these listed sites**:**

For Reportable Employer Superannuation Contribution purposes, please provide your residential address. Residential Address:

## Medical Practitioner superannuation contribution declaration

I understand that:

1. by signing this agreement, I am authorising SA Health to make contributions on my behalf to the fund nominated above and any additional percentage earnings stipulated
2. these contributions will be in addition to the minimum level of superannuation support required under the *Superannuation Guarantee (Administration) Act 1992*
3. my entitlement to payment for services rendered on or after the date of this agreement under the relevant South Australian Medical Schedule of Fees (SAMSOF) will be reduced to the extent that the contributions are paid by the Hospital to the fund
4. the amounts contributed by SA Health will be employer contributions to the superannuation fund
5. SA Health is not liable, either directly or indirectly, in respect of any matter concerning my contributions, unless such liability cannot be abrogated by statute
6. by signing below, I will indemnify SA Health from and against:
	1. any income tax or any other taxation liability whatsoever (including any administrative penalty, fine or other amount) that may become payable pursuant to any relevant taxation legislation and rulings;
	2. any other liability whatsoever not otherwise described above, in respect of the contributions by SA Health including any information supplied by SA Health; and
	3. all charges, costs, damages, disbursements, fees, losses suffered or incurred by SA Health in relation to any matter associated with the contributions by SA Health
7. I bear the complete and sole responsibility for
	1. seeking appropriate taxation and financial advice in respect of my contributions; and
	2. establishing and maintaining an account with the fund.

**Signature of Practitioner:**

**Name:**       **Date:**

## For more information

Rural Support Service

Clinical Workforce Finance Team

Health.RSSClinicalWorkforceFinance@sa.gov.au

Telephone: 0477 345 219

**sahealth.sa.gov.au/regionalhealth**

© Rural Support Service, SA Health, Government of South Australia. All rights reserved.