



Mappa Information Maintenance Schedule

This Mappa Information Maintenance Schedule forms part of the Mappa Website Contributor Information Terms & Conditions (the **Contributor Terms**). Along with the Contributor Terms, this Information Maintenance Schedule creates a contract between Aboriginal Health Council of Western Australia (ABN 48 114 220 478) of 450 Beaufort Street, Highgate WA 6003 (**AHCWA**) and the Contributor named herein. Words which are defined in the Contributor Terms and which are used in this Information Maintenance Schedule have the same meaning herein as in the Contributor Terms unless the context requires otherwise.

| No. | Item | Description |
|-----|-------------------------------------|---|
| 1. | Contributor | Name: ABN: Address: Phone: Email: |
| 2. | Contributor's Administrator | Name: <i>[Should match Contributor Administrator in Information Authorisation Agreement]</i> Position: Phone: Email: |
| 3. | Contributor Contract Manager | Different to the Contributor's Administrator: Name: <i>[Should match Information Authorisation Agreement]</i> Position: Phone: Email: |
| 4. | AHCWA Contract Manager | Name: <i>[Should match Information Authorisation Agreement]</i> Position: Phone: Email: |

5. Contributor Information requirements

The following agreed details must remain consistent at all times to ensure compatibility with Mappa Website. This Information Maintenance Schedule confirms that all future submissions of Contributor Information to The Mappa Portal and Mappa Website will remain consistent in this format.

Please delete existing fields pre-populated as examples and replace with actual content relevant to your organisation.

| WHAT | HOW | BY | TYPE | DETAILS | WHEN | NOTES |
|--|--|--|--|---|---|--------------|
| Contributor Information <i>Specify each health area submitted (per submission method) e.g. Mental Health Sites</i> | Submission Method <i>Email to mappadata@ahcwa.org, or AHCWA's FTP or online via The Mappa Portal</i> | To be submitted by <i>Contributor personnel (e.g, employee) full name, ph, email</i> | File Format to submit <i>e.g. Excel (csv) file</i> | Fields and Field Types <i>Small number of fields - specify the individual fields below. Large number of fields - attach the document to this Schedule. Write in the field below 'All fields match as per attached submission labelled'.</i> | Update Frequency <i>Frequency - Annually / Every 6 months / quarterly bi-monthly / monthly / fortnightly / weekly / daily Specify Due Dates</i> | Notes |
| <i>Hospitals</i> | | | | | <i>Quarterly by 30SEP, 31DEC, 31MAR, 30JUN</i> | |
| <i>Mental Health</i> | | | | | | |
| <i>Visiting Medical Specialist Schedules</i> | | | | | | |
| <i>Visiting Allied Health Professional Schedules</i> | | | | | | |

6. Other requirements

The Contributor's Administrator is responsible for fulfilling the Contributor Information requirements, including providing updates in accordance with this Information Maintenance Schedule.

The Contributor Contract Manager and the AHCWA Contract Manager are responsible for management of the contractual agreements between the parties.

[Insert any other requirements]

The Contributor warrants and agrees that:

- a) this Information Maintenance Schedule is incorporated into the Contributor Terms as amended from time to time, upon execution;
- b) they will comply, and will ensure that the Contributor's Administrator and all other Contributor personnel, comply with this Information Maintenance Schedule;
- c) the information provided in this Information Maintenance Schedule is true and correct, and complies with the Contributor Terms;
- d) the Contributor Information when supplied in accordance with this Information Maintenance Schedule is up-to-date and true and correct;
- e) they have the full right, power and authority to enter into this Information Maintenance Schedule.

Executed as a Deed

EXECUTED by and on behalf of **the Contributor** by its authorised officers:

Signature of Authorised Officer

Name of Authorised Officer

Position

Date

Signature of Witness

Name of Witness

Position

Date

EXECUTED by the **Aboriginal Health Council of Western Australia** in accordance with section 127 of the *Corporations Act 2001* (Cth) by its authorised officers:

Signature of Authorised Officer

Name of Authorised Officer

Position

Date

Signature of Authorised Officer

Name of Authorised Officer

Position

Date