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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DEP Repair and Maintenance JOB SHEET** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **DEP RM-2** | |
| R&M Contractor to complete and forward to DEP Work Unit with invoice | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date of Request:** | | | | 24 / 09 / 2025 | | | | | | **DEP Order Number/Job Number:** | | | | | | | | | | | | | | JN-2025-09-881 | | | | | | |
| **Date of Repair:** | | | | 24 / 09 / 2025 | | | | | | **DEP ‘T’ Number:** | | | | | | | | | | | | | | T-4512 | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Client Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Given Names: | | Jane | | | | | | | | | | | | | | | | | Surname: | | | | | Harrison | | | | | | |
| Contact Phone: | | 08899900555 | | | | | | | Address: | | | | 45 Mitchell, Darwin, NT 800 | | | | | | | | | | | | | | | | | |
| Location of Repairs: | | | | | | | Same as address | | | | | | | | | | | | | | | | | | | | | | | |
| State the R&M Request: | | | | | | | The control remote for the hospital bed is not working. The head adjustment function is unresponsive. | | | | | | | | | | | | | | | | | | | | | | | |
| **Equipment Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Equipment Type: | | | Engine | | | | | | | | | | | | | | | | | | | | Serial No: | | | SN-MCP300-789456 | | | | |
| Equipment Brand/Make/Model: | | | | | | | | MetCare Pro / MCP-300 | | | | | | | | | | | | | | | | | | | | | | |
| **Job Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Works above $300 for non-powered and $500 for powered nominated equipment items require a quote to DEP.  If equipment is deemed as irreparable, complete Job Sheet and notify DEP for arrangements to return equipment. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Prior To Commencing Work -** Is a quote to DEP required? | | | | | | | | | | | | | | | | |  | Yes | | | |  | | No | | |  | | | |
| If **Yes,** send quote to DEP. Date quote sent: | | | | | | | | | | | | /    / N/A | | | | | | | | | | If **No,** proceed with job | | | | | | | | |
| **DEP Approval Received?** | | | | | | | | | | |  | | | Yes - **Proceed** with job | | | | | | |  | No - **Do Not Proceed** with job | | | | | | | | |
| Description of work performed: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tested the control remote and found a faulty connection in the cable. Replaced the 8-pin connector head on the remote's cable. Tested all bed functions (head, foot, and height adjustment) to confirm they are now fully operational. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Time Record** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date | | | | | | 25/09/2025 | | | | | | | | |  | | | | |  | | | | | | | |  | | |
| Start | | | | | | 10:00 AM | | | | | | | | |  | | | | |  | | | | | | | |  | | |
| Finish | | | | | | 10:45 AM | | | | | | | | |  | | | | |  | | | | | | | |  | | |
| Time Taken | | | | | | 45 minutes | | | | | | | | |  | | | | |  | | | | | | | |  | | |
| **Materials Used** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date | Item Description *(f used other parties please give details and company name)* | | | | | | | | | | | | | | | QTY | | | Cost $ | | | | | | Total $ | | Source *(DEP Parts / New / Other)* | | | |
| 25 / 09 / 2025 | 8-pin Door Control Connector | | | | | | | | | | | | | | | 1 | | | 15.50 | | | | | | 15.50 | | New | | | |
| /    / |  | | | | | | | | | | | | | | |  | | |  | | | | | |  | |  | | | |
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| /    / |  | | | | | | | | | | | | | | |  | | |  | | | | | |  | |  | | | |
| Total $, Materials = | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |
| Technician Name: | | | | | David Chen | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature: | | | | |  | | | | | | | | | | | | | | | | | | | | | | Date: | | | 25 / 09 / 2025 |
| Client / Carer Name *(verifying work undertaken)*: | | | | | | | | | | | | | | Jane Harrison | | | | | | | | | | | | | | | | |
| Signature: | | | | |  | | | | | | | | | | | | | | | | | | | | | | Date: | | | 25 / 09 / 2025 |