



OFFICE USE ONLY				
Receipt No				
Term	1	2	3	4
Wise.Net (Entered date)	____/____/____			
Register No.				
Concession		YES Copy Attached	NO	

Course and Activity Registration Form (Non Pre-Accredited Courses)

Program Code (office use only):

Class: _____

Day: _____ **Start Time:** _____

Title (Please Tick One Box Only)

Mr Miss Mrs Ms Other _____

First name: _____

Last name: (family name or surname) _____

Middle Name: _____

Preferred Name: _____

Please circle your age group:

- 15-20
- 21-30
- 31-40
- 41-50
- 51-60
- 61-70
- 71-80
- 80-90
- 90-100

Gender: (Please Tick One Box Only)

Male Female Intersex

Contact Details

Home (Tel): _____

Work (Tel): _____

Mobile: _____

Email: _____

Current residential address

Flat/Unit No. _____ Street No _____

Street Name _____

Suburb _____ Postcode _____

Postal address (leave blank if same as residential address)

Flat/Unit No _____ Street No _____

Street Name _____

Suburb _____ Postcode _____

Country of Birth:

Australia Other – please specify: _____

Are You? (Please tick the box who best describe you)

- Are you Aboriginal?
- Are you a Torres Strait Islander?
- Are you Aboriginal and a Torres Strait Islander?
- No, I am Neither

Language and Cultural Diversity

Do you speak a language other than English at home?

English only Other – please specify: _____

Next of Kin

Emergency Contact Name: _____

Relationship to Applicant: _____

Contact Phone Number: _____

Address: (leave blank if same as Participant's address)

Street _____

Suburb _____ Postcode _____

How did you hear about us?

- North and West Melbourne News
- Brochure
- Website
- Friend
- Job agency
- Other (Please specify) _____

Concession

Do you hold any of the following Health care cards?

<input type="checkbox"/>	New start allowance
<input type="checkbox"/>	Aus Study
<input type="checkbox"/>	Pensioner concession
<input type="checkbox"/>	Veteran's Gold
<input type="checkbox"/>	Other (please specify)

Health Care Card Number:

Expiry date:

Medicare Number:

Expiry date:

Disability

Do you consider yourself to have a disability, impairment, or long-term condition?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

If yes, please indicate the area of disability, impairment or long-term condition.

(You may indicate more than one area)

<input type="checkbox"/>	Hearing / Deaf
<input type="checkbox"/>	Physical
<input type="checkbox"/>	Intellectual
<input type="checkbox"/>	Learning
<input type="checkbox"/>	Mental illness
<input type="checkbox"/>	Acquired Brain Impairment
<input type="checkbox"/>	Vision
<input type="checkbox"/>	Medical Condition
<input type="checkbox"/>	Other

Special Requirements (optional)

Do you have any medical conditions we should know about?

Food Allergies / Restrictions

I consent to The Centre seeking medical assistance if required.

Yes No

Medicare Number:

Expiry date:

DECLARATION

Agreement and Contract

- (1) The Applicant agrees to be bound by The Centre (hereafter called the provider) rules and regulations in force from time to time, and otherwise to follow acceptable codes of behaviour and attendance and show concern for other participants.
- (2) I understand that The Centre is required to submit data sourced from this form to the Department of Health and Human Services and the City of Melbourne as a regulatory reporting requirement.
- (3) The information contained on my form may be used by The Centre for funding, administrative, regulatory and/or research purposes.

I have read and I consent to the collection, use and disclosure of my personal information pursuant to the information detailed.

I grant permission / I do not grant permission to The Centre, its employees and agents, to take and use visual/audio images of myself.

I release The Centre, its employees and agents, including any firm authorised to publish and/or distribute a finished product containing the images, from any claims, damages or liability which I may ever have in connection of the images or printed material used with the images.

I waive any right to inspect or approve the finished images or any printed or electronic matter that may be used with them.

I agree to abide by the Code of Conduct.

Name:

Date:

Signature: