Central Australian Remote Health Development Services (CARHDS)

WORKSHOP ENROLMENT

FORM 78

1. Workshop topic:______________________________ Delivery dates: _______________________

Venue: ____

Facilitators: ____

2. Personal Details

Family Name: __________________________________ Given Names: ______________________________

Female ☐ or Male ☐ USI Number ______________________________

Date of Birth ____________________________________

3. Contact Details

Mobile: __________________________________ Work Ph*:* ______________________________

Email: ____

Postal Address: ____

3. Employer: ____ Supervisor: _________________________

What is your occupation (please tick one below).

Choose from the following:

- ☐ Aboriginal Health Practitioner (AHP)
- ☐ Aboriginal Health Worker (AHW)
- ☐ Community Health Worker
- ☐ Trainee Health Worker
- ☐ Apprentice Health Worker
- ☐ Aboriginal Liaison Officer
- ☐ Allied Health Professional
- ☐ Council/Community Employee
- ☐ Health Administrator
- ☐ Other ______________________________

4. Are you of Aboriginal and /or Torres Strait Islander origin? (For persons of both Aboriginal and Torres Strait Islander origin, mark both "Yes")

☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No

Signature: _____________________________________ **Date:** ______________________________

Please email to CARHDS – reception@carhds.org.au
Or fax to 89532046