

Fawkner Community House Enrollment Form

Enrolled by _____

Date _____

Course/Group title: _____ Day, time: _____

Name:

Mr/Mrs/Miss/Ms _____ Date of birth: _____
(Please circle) First name Family name

Address: _____

Postcode: _____

Phone: Home: _____ Work: _____ Mobile: _____

Emergency Contact: Name: _____ Phone number: _____

Country of birth: _____ Language spoken at home: _____

Which year did you arrive in Australia? _____

Do you have Aboriginal or Torres Strait Islander background? Yes/No

Do you need childcare in order to do this course? Yes/No

Do you want to be a member of Fawkner Community House? Yes/No

How did you find out about this course?

Newspaper
 School newsletter

Flyer
 Term brochure

Word of mouth
 Other _____

How many years of schooling have you completed?

Year 12 or more
 Year 11

Year 10
 Year 9 or less

Are you currently:

In paid full-time work
 Unpaid family worker

Seeking part-time work
 In paid part-time work

Seeking full-time work
 Not working and not seeking work

Do you want to do this course or group for:

Work
 Leisure/recreation

Health
 Social activity

Personal development
 To help find a job

PLEASE TURN OVER

Are you on a Health Care or concession card? Yes/No

If yes, what is your concession card number? _____

What is the expiry date? _____

What type of concession type applies to you?

<input type="checkbox"/> Age pension	<input type="checkbox"/> Carers pension	<input type="checkbox"/> Disability Support pension
<input type="checkbox"/> Family allowance supplement	<input type="checkbox"/> Mature Age allowance	<input type="checkbox"/> Youth allowance
<input type="checkbox"/> Newstart allowance	<input type="checkbox"/> Newstart Mature Age	<input type="checkbox"/> Wife pension
<input type="checkbox"/> Parenting payment single	<input type="checkbox"/> Partner allowance	<input type="checkbox"/> Widow allowance
<input type="checkbox"/> Sickness allowance	<input type="checkbox"/> Special benefit	<input type="checkbox"/> Other

Do you consider yourself to have a disability, impairment or long-term condition? Yes/No

If yes please tick the appropriate box/es:

<input type="checkbox"/> Hearing problems/deafness	<input type="checkbox"/> Learning disability	<input type="checkbox"/> Vision impairment
<input type="checkbox"/> Physical disability	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Other, please state
<input type="checkbox"/> Intellectual disability	<input type="checkbox"/> Acquired brain injury	

Do you give permission for us to take your photograph? Yes/No

If yes, do you give permission for your photograph to be displayed or published for promotional purposes? Yes/No

Fawkner Community House has a privacy policy and will treat all details given in accordance with the Privacy Regulations.

I declare all details provided on this form are true and correct to the best of my knowledge. I agree for relevant information to be released to funding bodies for contractual reporting. I agree to abide by the rules and regulations of Fawkner Community House.

Student name _____ Signature _____ Date: _____

Signature witnessed by staff member: _____

Office Use Only

	<i>Receipt Number</i>	<i>Date of Receipt</i>	<i>Amount Paid</i>
<i>Term 1</i>			
<i>Term 2</i>			
<i>Term 3</i>			
<i>Term 4</i>			