



MUSCULOSKELETAL
AUSTRALIA

Warm Water & Chair-based Leader Training Application Form 2020

Date of course _____ Location _____

Please tick the box of component/s you are applying for)

- Warm water exercise
- Chair-based exercise
- Warm water & chair-based exercise

SECTION A: PERSONAL DETAILS

1. Name

Family name (surname) _____ Given name/s _____

2. Birth Date

Day/month/year (dd/mm/yy)

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3. Gender

Male Female Other

3. Contact Details

Street address _____ Suburb _____

Postcode _____ State _____ Email _____

Telephone (h) _____ (w) _____ (m) _____

4. Disability

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

If Yes, then please indicate the areas of disability, impairment or long-term condition

Hearing/Deaf Physical Intellectual Learning Mental Illness Acquired Brain Impairment

Vision Medical Condition Other _____

Do you have a muscle, bone or joint condition? (Please tick) Yes No

If yes, please give details _____

5. Employment

Which of the following categories best describes your current employment status? (Tick one box only)

Employed Student Home duties Retired Volunteer Unemployed

Please complete the following if working or volunteering:

Workplace _____

Current role _____

Qualification _____

Work/Volunteer email (if applicable) _____

SECTION B: PROGRAM/COURSE

How did you find out about this course? _____

What are your expected learning outcomes from attending this program/course?

MSK Leader Training and Update Record*:

MSK leader training courses	Year attended	MSK leader update courses	Year attended

* If enrolling into update training, you may be requested to supply a copy of your initial training certificate

SECTION C: PROGRAM/COURSE REQUIREMENTS

WARM WATER AND CHAIR-BASED EXERCISE LEADER COURSE

Participants with no formal training in health or exercise are eligible to attend but must have ongoing support from a qualified health or exercise professional before enrolling in this course. Please complete this box if you are **NOT** a health professional or you **DO NOT** have a formal qualification in exercise (i.e. Cert III/IV in Fitness).

Name of qualified health or exercise professional _____

Organisation: _____

Profession Physiotherapist Exercise physiologist
 Occupational Therapist Other _____

Please complete the following:

I (name of qualified professional) _____ agree to provide ongoing support and supervision as required for (name of course applicant) _____ to ensure that they lead safe and effective exercise classes in the community.

Signed (qualified professional) _____ Date: _____

SECTION D: EMERGENCY CONTACT

Name _____

Telephone _____ Relationship _____

SECTION E: PAYMENT DETAILS

PAYMENT OPTIONS: Please tick relevant box

Leader Combined (3 days)	Cost	Leader – Warm water only (3 days)	Cost	Leader – Chair-based only (3 days)	Cost
<input type="checkbox"/> Individual fee	\$665	<input type="checkbox"/> Individual fee	\$630	<input type="checkbox"/> Individual fee	\$530
<input type="checkbox"/> MSK Peer Support Group	\$350	<input type="checkbox"/> MSK Peer Support Group	\$300	<input type="checkbox"/> MSK Peer Support Group	\$280

Payment by: Cash Cheque Money order Visa MasterCard
Cheques and Money orders to be made payable to Musculoskeletal Australia

Amount: \$ _____

Card no _____ / _____ / _____ Exp _____ / _____

Cardholder's name _____ Signature _____

If requesting a tax invoice for your organisation, please complete this section.

Name _____ Position _____

Organisation _____

Address _____

_____ Postcode _____

Telephone _____ Fax _____

SECTION F: DECLARATION

Checklist: please tick

- I understand that if I wish to withdraw from this specific course on the date nominated, I must notify Musculoskeletal Australia (MSK) in writing and enclose the course fee receipt. I understand that if I choose to withdraw more than ten working days before this specific course commences, I will receive a fee refund less a 20% administration fee.
- I understand that I will not receive a refund if I withdraw from the course less than seven working days prior to the date nominated for this specific course, except for medical reasons. In this instance, I note that I will be required to provide a medical certificate.
- I have completed all relevant sections of the application form and provided correct payment details.

I, (name) _____ wish to participate in the training course on the date nominated as stated on this application form. I understand that my name, address, and contact details (provided on this form) will be added to the MSK database for advance notice of education and training programs and relevant information. From time to time, MSK will contact me with various opportunities for supporting people with muscle, bone & joint conditions and research projects. I understand that MSK will not on-sell my personal details to any other organisation and that MSK complies with the *Privacy Amendment (Private Sector) Act 2000*. **The information I have provided in this form is true and correct at the time of completion.**

Signature: _____ Date: _____

SECTION G: MUSCULOSKELETAL AUSTRALIA CONTACT

PLEASE RETURN COMPLETED FORM AND PAYMENT TO:

Post Health Promotion Coordinator, Musculoskeletal Australia, PO Box 130, Caulfield South, Victoria 3162

Fax 03 8531 8045 **Email:** programs@msk.org.au

Enquiries to Health Promotion Coordinator **Ph:** (03) 8531 8045

Toll free (country callers only): 1800 263 265

Office use only

Trainer to complete

Meets course requirements Yes No

Trainer signature _____

Date _____

Admin to complete

Payment processed Date _____

Checked database Date _____

Entered on tracking sheet Date _____