ACT
Mental Health
Consumer Network

Training Registration Form

Name: _____

Street Address: _____

(Suburb)_____(Postcode) _____

Phone: (h)_____(m) _____

Email: _____

1. Which training are you registering to attend? *(Training Name and Date)*

_____

2. Do you have any additional needs? *(e.g. wheelchair accessibility, dietary requirements)*

_____

3. Please explain why you want to attend the above training.

_____

_____

4. How did you hear about this course?

_____

_____

Signed: _____ Date: _____

Please return the form to peer.education@actmhcn.org.au or the address listed below.

Thank you for your registration. We will confirm your place as soon as possible.

ACT Mental Health Consumer Network
Phone: (02) 6230 5796
P.O. Box 469, Civic Square, ACT 2608