

Client **Group** Registration Form



Given Name		Last Name	
Preferred name (if different)			
Date of Birth	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)		
Street Address			
Town / Suburb	State	NSW	Postcode 2795
Email address:			
Add me to the CWWHC newsletter email list (usually once per term) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Telephone	Mobile		
	Other	This is my: <input type="checkbox"/> Home <input type="checkbox"/> Work number	
Can we contact you at the above address, number or email? <input type="checkbox"/> Yes <input type="checkbox"/> No (please specify)			
Emergency Contact	Name:		Phone:
Their relationship to you?			
In which country were you born?	<input type="checkbox"/> Australia <input type="checkbox"/> Other (please specify)		
What country have you lived in for most of your life?	<input type="checkbox"/> Australia <input type="checkbox"/> Other (please specify)		
Are you Aboriginal / Torres Strait Islander?	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> No		
What is your cultural background?	<input type="checkbox"/> Australian <input type="checkbox"/> Other (please specify)		
What language do you prefer to speak?	<input type="checkbox"/> English <input type="checkbox"/> Other (please specify)		
Do you need an interpreter?	<input type="checkbox"/> No <input type="checkbox"/> Yes → If "Yes", for what language?		
What is your primary source of income?	<input type="checkbox"/> Pension/Benefit/Student <input type="checkbox"/> Employed <input type="checkbox"/> Sole Trader <input type="checkbox"/> No Income <input type="checkbox"/> Other		
If "Employed", on what basis?	<input type="checkbox"/> Casual <input type="checkbox"/> Part time <input type="checkbox"/> Full time		
Are you	<input type="checkbox"/> Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Transgender <input type="checkbox"/> Intersex <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Other		
Are you	<input type="checkbox"/> Heterosexual (Straight) <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Other		
Do you have disability or suffer from a long-term / chronic health problem? <input type="checkbox"/> No <input type="checkbox"/> Yes			
<i>If "Yes", what kind of disability or health problem?</i>			
Are you a Carer?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who are you caring for? <input type="checkbox"/> Child <input type="checkbox"/> Spouse/partner <input type="checkbox"/> Parent	
		<input type="checkbox"/> Other Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Other:	
CWWHC is a Work Development Order Sponsor. Do you have any outstanding fines?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have a Visa?	<input type="checkbox"/> No <input type="checkbox"/> Yes Visa type: (please specify)		
How did you hear about our Centre or this group?	<input type="checkbox"/> Social Media <input type="checkbox"/> Website / Google <input type="checkbox"/> Centre Flyer / Pamphlet		<input type="checkbox"/> Professional / Organisation <input type="checkbox"/> Newspaper / Magazine / Radio <input type="checkbox"/> Friend / Associate / Relative
			<input type="checkbox"/> Walk by <input type="checkbox"/> Other

Please turn over →

1. Central West Women’s Health Centre Inc. is bound by Policies, *Code of Conduct for Unregistered Health Practitioners (Public Health Regulation 2012 NSW)*, the *Australian Privacy Principles, Privacy Act 1988* and the *Privacy Amendment (Enhancing Privacy Protection) Act 2012*. If you would like a copy of our Privacy Policy please ask at reception.

2. The information that we collect about you is regarded as personal information and some details are regarded as sensitive information therefore attracting particular obligations in respect of collection, security and disclosure.

The purpose for collecting the information is to enable our practitioner/s to gain a better understanding of your background and therefore assist us to work more effectively together. The Centre also collates de-identified (ie. you cannot be identified) data for reporting and funding purposes. The Centre may also contact you for evaluation purposes or to keep you informed of other activities (eg. a particular group) that you may like to participate in.

While the supply of the requested information by you is voluntary, if you cannot provide or do not wish to provide the information sought, this may affect the effectiveness of our working relationship.

Any information collected about you will be stored in a secure environment and will not be used for any purpose other than that which is indicated above. If the Centre wishes to use information about you for any other purpose, we will seek consent from you for that purpose. No third party will have access to this information without your consent.

You have a right to access the information concerning yourself for the purpose of amendment or correction, in accordance with the relevant procedures under the Act.

3. If any of your personal information that we have collected changes (eg. your address or phone number) please advise us at your earliest convenience.

4. Client files are randomly selected for auditing purposes to ensure our practitioners are meeting the required standards for record keeping. To provide us with permission to audit your file, please tick below.

	Yes	No
I consent to my file being made available for Centre auditing purposes	<input type="checkbox"/>	<input type="checkbox"/>
I have received a Rights & Responsibilities Brochure	<input type="checkbox"/>	<input type="checkbox"/>
I have read and understood all the above information	<input type="checkbox"/>	<input type="checkbox"/>

Group you are enrolling in

Group Name: _____

Start Date: ____/____/____

Payment (if applicable)

Date paid: ____/____/____ Cash EFTPOS Direct Transfer

Do you have any food intolerances/special requirements? _____

Preferred Name (for name tag) _____

Name: **Signature:**

Date:/...../.....