For Centre Staff Completion	Registration Date:	Consent to Audit? ☐ Yes ☐ No	Client File Number:

Client **Group** Registration Form

CENTRAL WEST WOMEN'S HEALTH CENTRE
SUPPORT FOR WOMEN & CHILDREN

Given Name		Last Name			
Preferred name (if different)					
Date of Birth	☐☐ / ☐☐ / ☐☐☐☐ (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) ☐ Yes ☐ No

Telephone Mobile	
Other	This is my: ☐ Home ☐ Work number

Can we contact you at the above address, number or email? ☐ Yes ☐ No …….. (*please specify*)

Emergency Contact	Name:		Phone:	
Their relationship to you?				

In which country were you born?	☐ Australia ☐ Other …… (*please specify*)
What country have you lived in for most of your life?	☐ Australia ☐ Other …… (*please specify*)
Are you Aboriginal / Torres Strait Islander?	☐ Aboriginal ☐ Torres Strait Islander ☐ No
What is your cultural background?	☐ Australian ☐ Other ..... (*please specify*)
What language do you prefer to speak?	☐ English ☐ Other ..... (*please specify*)
Do you need an interpreter?	☐ No ☐ Yes → If "Yes", for what language? ……
What is your primary source of income?	☐ Pension/Benefit/Student ☐ Employed ☐ Sole Trader ☐ No Income ☐ Other
If "Employed", on what basis?	☐ Casual ☐ Part time ☐ Full time
Are you	☐ Female ☐ Non-binary ☐ Transgender ☐ Intersex ☐ Prefer not to say ☐ Other ……
Are you	☐ Heterosexual (Straight) ☐ Bisexual ☐ Lesbian ☐ Prefer not to say ☐ Other ……

Do you have disability or suffer from a long-term / chronic health problem? ☐ No ☐ Yes

If "Yes", what kind of disability or health problem?

Are you a Carer?	☐ No ☐ Yes	Who are you caring for? ☐ Child ☐ Spouse/partner ☐ Parent ☐ Other Family Member ☐ Friend ☐ Other: ……..

CWWHC is a Work Development Order Sponsor. Do you have any outstanding fines? ☐ No ☐ Yes

Do you have a Visa? ☐ No ☐ Yes Visa type: …… (*please specify*)

How did you hear about our Centre or this group?	☐ Social Media ☐ Website / Google ☐ Centre Flyer / Pamphlet	☐ Professional / Organisation ☐ Newspaper / Magazine / Radio ☐ Friend / Associate / Relative	☐ Walk by ☐ Other ……

Please turn over →

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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	☐	☐
I have received a Rights & Responsibilities Brochure	☐	☐
I have read and understood all the above information	☐	☐

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: ……/……/……..