



**Queensland Health Staff please note this form does not replace your local
Conference/Workshop/Training Application processes**

ABN: 66 329 169 412

First Name:		Last Name:	
Postal Address:			
			Post Code:
Phone: (H)	(W)	(F)	(M)
Email:			A reminder SMS will be sent to this number prior to the training
* You MUST provide an email address for confirmation and documents to be emailed to you.			

<input type="checkbox"/> Queensland Health Employee		<input type="checkbox"/> Other	
District:		Organisation:	
Service:		Address:	
Professional Background	Nurse – CNC/NUM Nurse – Clinical Nurse - Director Nurse- Enrolled Nurse – Registered Assistant in Nursing Occupational Therapist	Oral Health/Dental Project Officer Psychiatry Registrar Psychiatrist Psychologist Social Worker Speech Therapist	Support Worker Team Leader Other <i>(Please specify)</i> -----
Mental Health Employee		Non Mental Health Employee	

Attendance Approved Yes No	Line Manager Name:
	Line Manager Email:

Training	Date	Training	Date
QC2 Suicide Risk Assessment & Management		30907QLD Course in Administering a Mental State Examination (complete Part A)	
QC10 Case Management		QC9 Critical Components of Risk Assessment and Management for the Mental Health Practitioner	
QC11 Provide a Brief Intervention		QC14 Mental Health Assessment & Capacity	
QC8 Introduction to Supervision Training		QC13 Capacity Assessment	
QC4 "Supervisor" Training"		QC15 Advanced Supervision for Clinical Educators (complete Part B)	
QC12 "Supervising Supervisors" Training		QC3 Mental Health Educator Development Workshop	

Do you have any special needs which may impact on how this training should be delivered to you? (e.g. wheelchair access) If yes please provide details. Yes No	Do you have any special dietary requirements? If yes please provide details. Yes No
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How did you hear about our programs?	Internet	Previous attendance	Other (Please specify)
QCMHL newsletter	Team Leader	Poster	
QCMHL Courses & Resources	Educator	Email	
QHEPS	Colleague	E-alert	-----

TO SUBMIT YOUR COMPLETED REGISTRATION FORM

Post to: QCMHL Training Coordinator
Locked Bag 500
SUMNER PARK BC QLD 4074

Fax to: 3271 8851

Email to: qcmhltraining@health.qld.gov.au

Training costs are:	Queensland Health Practitioners	Free
	Other	\$190/day

Part A

Course Offer:	30907QLD Course in Administering a Mental State Examination																
Unit:	QLD250MEN01A Conduct a Mental State Examination																
Study reason: Of the following categories, which BEST describes your main reason for undertaking this course? It was a requirement of my job Professional development points I wanted extra skills for my job To get a better job or promotion For personal interest or self-development To get into another course of study		Of the categories below which BEST describes your current employment status? (Tick ONE box only) <table border="0"> <tr> <td>Full-time employee</td> <td>Part-time employee</td> </tr> <tr> <td>Self employed – not employing</td> <td>Employer</td> </tr> <tr> <td>Others</td> <td>Unemployed – seeking full-time work</td> </tr> <tr> <td>Employed – unpaid worker in a family business</td> <td>Unemployed – seeking part-time work</td> </tr> <tr> <td>Not employed – not seeking employment</td> <td></td> </tr> </table>		Full-time employee	Part-time employee	Self employed – not employing	Employer	Others	Unemployed – seeking full-time work	Employed – unpaid worker in a family business	Unemployed – seeking part-time work	Not employed – not seeking employment					
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Self employed – not employing	Employer																
Others	Unemployed – seeking full-time work																
Employed – unpaid worker in a family business	Unemployed – seeking part-time work																
Not employed – not seeking employment																	
What is your highest COMPLETED schooling level? <table border="0"> <tr> <td>Year 12</td> <td>Year 11</td> </tr> <tr> <td>Year 10</td> <td>Year 9 or equivalent</td> </tr> <tr> <td>Year 8 or below</td> <td>Did not go to school</td> </tr> </table>		Year 12	Year 11	Year 10	Year 9 or equivalent	Year 8 or below	Did not go to school	Have you SUCCESSFULLY COMPLETED any of the qualifications listed below? Yes ** No ** If YES, please tick the appropriate box Bachelor degree or higher degree Advanced diploma or associate degree Diploma or associate diploma Certificate IV (or advanced certificate/technician) Certificate III (or trade certificate) Certificate II Certificate I Certificate other than above									
Year 12	Year 11																
Year 10	Year 9 or equivalent																
Year 8 or below	Did not go to school																
In which year did you complete the above school level?																	
In which country were you born? Australia Other, please specify:																	
Do you speak a language other than English at home? No – only English Other – please specify:																	
How well do you speak English? <table border="0"> <tr> <td>Very well</td> <td>Well</td> </tr> <tr> <td>Not well</td> <td>Not at all</td> </tr> </table>		Very well	Well	Not well	Not at all	Do you consider yourself to have a disability, impairment or long term condition? Yes ** No ** If YES, please tick the appropriate box: <table border="0"> <tr> <td>Mental illness</td> <td>Acquired brain impairment</td> </tr> <tr> <td>Vision</td> <td>Medical condition</td> </tr> <tr> <td>Hearing / deaf</td> <td>Physical</td> </tr> <tr> <td>Intellectual</td> <td>Learning</td> </tr> <tr> <td>Other (please specify):</td> <td></td> </tr> </table>		Mental illness	Acquired brain impairment	Vision	Medical condition	Hearing / deaf	Physical	Intellectual	Learning	Other (please specify):	
Very well	Well																
Not well	Not at all																
Mental illness	Acquired brain impairment																
Vision	Medical condition																
Hearing / deaf	Physical																
Intellectual	Learning																
Other (please specify):																	
Do you identify as Aboriginal or Torres Strait Islander? <table border="0"> <tr> <td>No</td> <td>Yes, Aboriginal</td> </tr> <tr> <td>Yes, Torres Strait Islander</td> <td>Yes, Aboriginal and Torres Strait Islander</td> </tr> </table>		No	Yes, Aboriginal	Yes, Torres Strait Islander	Yes, Aboriginal and Torres Strait Islander												
No	Yes, Aboriginal																
Yes, Torres Strait Islander	Yes, Aboriginal and Torres Strait Islander																
Date of birth:	Male	Female															
Privacy statement: As a registered training organisation, the Queensland Centre for Mental Health Learning (QCMHL) is legislated to collect information listed on this form to ensure adequate records are maintained for accreditation purposes and to best meet your needs as a client. QCMHL may be required by law to give some of your enrolment information to an external agency (eg Commonwealth or State Government Departments) under contractual reporting arrangements.																	
<ul style="list-style-type: none"> I will abide by Queensland Health's policies and procedures during this training (Queensland Health Code of Conduct) All information I have supplied on this enrolment form is accurate to the best of my knowledge 																	
Applicant's signature **:..... Date:																	
** Please note: Any unsigned form will be returned to you. Enrolment cannot be accepted without a signed, completed enrolment form																	

Part B

Course Offer:	Advance Supervision for Clinical Educators																
Which of the following best describes your current role? (please tick only one) <table border="0"> <tr> <td>Discipline Director</td> <td>Clinician</td> </tr> <tr> <td>Workforce Development Officer</td> <td>Project Officer/Researcher</td> </tr> <tr> <td>Clinical Educator with direct student/ new graduate supervision responsibilities</td> <td>Program Manager</td> </tr> <tr> <td>Clinical Educator who supervises staff providing placements and / or support to new staff</td> <td>Trainer</td> </tr> <tr> <td>Clinical Service Manager</td> <td>Other (please specify):</td> </tr> </table>				Discipline Director	Clinician	Workforce Development Officer	Project Officer/Researcher	Clinical Educator with direct student/ new graduate supervision responsibilities	Program Manager	Clinical Educator who supervises staff providing placements and / or support to new staff	Trainer	Clinical Service Manager	Other (please specify):				
Discipline Director	Clinician																
Workforce Development Officer	Project Officer/Researcher																
Clinical Educator with direct student/ new graduate supervision responsibilities	Program Manager																
Clinical Educator who supervises staff providing placements and / or support to new staff	Trainer																
Clinical Service Manager	Other (please specify):																
In which of the following priority groups (identified by HWA) do you work? Select all categories that apply. <table border="0"> <tr> <td>Oral Health</td> <td>Primary Health</td> </tr> <tr> <td>Rural and Remote</td> <td>Mental Health</td> </tr> <tr> <td>Aged Care</td> <td>None of these areas</td> </tr> <tr> <td>Allied Health</td> <td></td> </tr> </table>		Oral Health	Primary Health	Rural and Remote	Mental Health	Aged Care	None of these areas	Allied Health		Which groups of students do you supervise? Select all categories that apply. <table border="0"> <tr> <td>Undergraduate</td> <td>Vocational Education and Training (VET)</td> </tr> <tr> <td>Post Graduate</td> <td>Vocational specialisation (e.g College of Physicians)</td> </tr> <tr> <td colspan="2">I currently do not have supervisory responsibilities but will do / or would like to in the near future</td> </tr> </table>		Undergraduate	Vocational Education and Training (VET)	Post Graduate	Vocational specialisation (e.g College of Physicians)	I currently do not have supervisory responsibilities but will do / or would like to in the near future	
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Rural and Remote	Mental Health																
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Post Graduate	Vocational specialisation (e.g College of Physicians)																
I currently do not have supervisory responsibilities but will do / or would like to in the near future																	
How long have you been engaged in Clinical Supervision? 0 - 2 years 3 - 5 years 5 + years	How many supervision courses have you completed previously? (These could be online, face to face or any combination of participation.) 0 - 2 courses 3 - 5 courses 5 + courses	How would you rate yourself as a student supervisor? Beginner Intermediate Advanced															

Payment Options for Non-Qld Health OR Non-Qld Health Mental Health Service Participants

Payments can be made by Cheque, Money Order or Credit Card. Applicants must pre-pay training fees to enable registration.

If you require an invoice before payment please tick this box

(Note: your registration form will need to be submitted at least 30 days before the training for the above option)

Please indicate your method of payment:

Cheque**

Money Order**

Mastercard

Visa Card

Credit Card Number:

Credit Cardholders Name (as appears on the card):

Credit Card Expiry Date:

Authorised amount: \$

Cardholder Signature:

Date:

(This is compulsory, credit card payments cannot be taken over the telephone)

****Cheque/Money Order must be made payable to: The Park – Centre for Mental Health**

Intra/Inter-District Journals available for Qld Health staff.

Government Dept Name:

District/Area:

Cost Centre Code:

Cost Centre Name:

I hereby authorise the transfer of \$ *(insert amount payable)* from the cost centre recorded above to effect payment of the training fee/s for applicant named on this registration form.

Expenditure Approval Officer Signature:

Expenditure Approval Officer Name:

Expenditure Approval Officer Title:

Expenditure Approval Officer
Telephone No:

Expenditure Approval Officer
Fax No:

SUBMIT YOUR COMPLETED REGISTRATION FORM TO:

Post to: QCMHL Training Coordinator
The Park – Centre for Mental Health
Locked Bag 500
SUMNER PARK BC QLD 4074

Fax to: QCMHL Training Coordinator
3271 8851