



Enrolment Form

Name of the course:		
First Name:	Last Name:	
Full name for Certificate:	Date of Birth:	
Email Address:	Home Phone:	
Street Address:	Suburb:	
State:	Postcode:	Country:
Work Phone:	Mobile Phone:	
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female	

Statistical Information (confidential)

What is your country of birth?	What language do you speak at home?
Are you still attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No	What year did you leave school?
Are you of Aboriginal and/or Torres Strait Islander origin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is your Australian citizenship/residency status?	<input type="checkbox"/> Australian Citizen <input type="checkbox"/> Permanent resident <input type="checkbox"/> Temporary resident
What is your current employment status?	<input type="checkbox"/> Full time employee <input type="checkbox"/> Part time employee <input type="checkbox"/> Employer <input type="checkbox"/> Self employed – not employing others <input type="checkbox"/> Employed–unpaid worker in family business <input type="checkbox"/> Unemployed –Not seeking employment <input type="checkbox"/> Unemployed–Seeking part time work <input type="checkbox"/> Unemployed – Not seeking paid work
What is the highest tertiary qualification you have completed?	<input type="checkbox"/> Certificate 1 <input type="checkbox"/> Certificate II <input type="checkbox"/> Certificate III (or Trade Certificate) <input type="checkbox"/> Certificate IV (or Advanced certificate/Technician) <input type="checkbox"/> Diploma (or Associate Diploma) <input type="checkbox"/> Bachelor Degree or Higher Degree <input type="checkbox"/> Advanced Diploma (or Associate Degree) <input type="checkbox"/> Miscellaneous education
Do you consider yourself to have any disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Hearing <input type="checkbox"/> Visual <input type="checkbox"/> Intellectual <input type="checkbox"/> Learning <input type="checkbox"/> Mental illness <input type="checkbox"/> Medical condition <input type="checkbox"/> Acquired brain impairment <input type="checkbox"/> Physical <input type="checkbox"/> Other

Consent to Release of Information: I , certify that the above information is correct and give DLA permission to release information to other RTO's for accreditation, RCC and/or RPL purposes.

Signed: _____ Date: _____