Registration Details

Dr.  Ms.  Mr.  Mrs.

Family Name: First Name:

D.O.B: Work Position:

Organisation/Company:

AHPRA Registration Number:

Address:

Suburb: Post Code:

Phone:

Email:

GENERAL INFO

|  |  |
| --- | --- |
| Please describe your current workexperience |  |

|  |  |
| --- | --- |
| Are there particular skills orareas of interest that you wouldlike to explore in the course? |  |

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| --- | --- |
| Do you have recent clinicalmaterial to discuss? |  Yes  No |

COURSE detailS

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| --- | --- | --- | --- |
| Course Title | Management of BPD Patients | Start Date | Friday 12th April 2024 |
| Day  Time | Fridays, weekly  10.00 a.m.- 11.15 a.m. (Adelaide) | Location | Online via Zoom |

PaymentS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Registration fees can be paid via Direct Deposit to:** | | | | | |
| **Account Holder:** | ADELAIDE INSTIUTE OF PSYCHOANALYSIS | **Bank Name:** | BANK OF SOUTH AUSTRALIA | **Cost** | $660.00 |
| **BSB NO:** | 105-032 | **ACC NO:** | 147 725 840 | **Reference** | Please put your **full name** under either Description/ Remitter |

COURSE AGREEMENT

**By filling out the registration form, you agree to comply with the Australian Privacy**

**Law obligations for health practitioners, including**:

* To maintain confidentiality of all clinical material presented in the course.
* Inform the course leader if I know or identify a patient/client discussed, so alternative arrangements can be made to protect the patient/clients confidentiality
* Not record any of the sessions.
* Discuss case vignettes to expand my existing knowledge and clinical skills.
* I understand that the course does not provide individual supervision or consultation for clinical management of my clients/patients for whom I retain full responsibility.

Please sign and email this completed form

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |
| Name |  | Email to | shanthisahawork@gmail.com |