ATLANTIC
HEALTHCARE TRAINING

REGISTRATION FORM TA 11/01

please affix a colour photo of yourself here

course details

Training for Therapy Assistants (Working in Aged Care)

Course No: TA 11/01

Commencing: 25th March 2011

Finishing: 15th July 2011

personal details

Title: Dr / Mr / Mrs / Ms / Miss

Full Name: ....

Address: ....

Suburb: .... Postcode: ....

Phone (H): .... (M): ....

Phone (W): .... Email: ....

optional

Preferred Name: .... D.O.B.: ....

Current Employer: ....How long there.......................................

For networking purposes I am willing for my name & phone number to be included on a contacts list, to be circulated to other course members (please circle)

YES NO

payment details

Cheque for: $ .... payable to Atlantic Healthcare Training

Money Order: $ .... payable to Atlantic Healthcare Training

Cash: $ .... Receipt No: ....

N.B. to be accepted, payment must accompany this registration form. No credit card facilities are available.

Atlantic Healthcare Training P.O. Box 77, Mt Hawthorn W.A. 6915
Phone: (08) 93883577 Fax: (08) 93883578
Email: admin@atlantichealth.com.au

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medical history

Full Name: ....

Phone (H): .... Mobile: ....

please circle the correct response to each question

Are you currently in a rehabilitation program?	YES / NO
Have you ever suffered a workplace injury?	YES / NO
Have you ever suffered from a back injury?	YES / NO
Have you ever suffered from a shoulder injury?	YES / NO
If yes to any of these, was the injury a Worker's Compensation claim?	YES / NO
If yes, did you have time off work?	YES / NO

Please give date and details of injury / accident. If more than one, please list:

....

....

....

If a Worker's Compensation claim, please give date settled ....

Do you have any other problems which would affect your ability to work in the aged care sector? YES / NO

Have you worked or been a patient in a hospital overseas, in the eastern states or in the north west of West Australia in the last 12 months YES / NO

declaration

I have answered the above questions to the best of my ability and believe them to be true and correct. I understand that Atlantic Healthcare Training (AHT) will NOT be liable for any injuries arising from a pre-existing medical condition or in respect of which a willfully false answer was given.

By registering with AHT, I agree to maintain strict confidentiality concerning verbal, written and electronic information regarding residents and / or client facilities. I understand that failure to maintain such confidentiality could result in AHT terminating my training.

Signature: .... **Witness:** ....

Date: ....

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therapy assistant experience

Full Name: ....

Registration for: OT ASSISTANT (OTA) PT ASSISTANT (PTA) THERAPY ASSISTANT (TA) Doing both OTA & PTA (please circle)

experience profile

Please outline your experience related to health care and aged care

Dates	Position	Place	Reason for Leaving

Please list all qualifications and relevant skills or interests (attach resume if available)

Dates	Course

Are you familiar with and feel competent in the following?

(please circle appropriate response for each)

ACFI Documentation	YES / NO
Aged Care Standards	YES / NO
OSH Requirements	YES / NO
Manual Handling	YES / NO
Working with people with dementia	YES / NO
Use of care plans	YES / NO
Program planning	YES / NO
Running small groups	YES / NO
Providing activities to high care / low care clients	YES / NO

If applying for OTA and PTA please complete both of the below sections.

OTA applicants

Are you currently working in an OTA position? (Please circle) YES / NO

If YES, Site:.... .... Hours per week...

Name of Supervising Registered Occupational Therapist (0T) ....

Contact Number for OT Work.. Mobile ....

If NO, have you arranged a **volunteer** work placement? YES / NO

(If NO, you will need to organize your own placement & complete the details below)

Site name:..Volunteer hours per week..

Date starting volunteer work...

Name of Supervising Registered Occupational Therapist (OT) ....

Contact Number for OT Work.. Mobile..

PTA applicants

Are you currently working in a PTA position? YES / NO

If YES, where? ....Hours per week..

Name of Supervising Registered Physiotherapist (PT) ....

Contact Number for PT Work...................................... Mobile..

If NO, have you arranged a **volunteer** work placement? YES / NO

(If NO, you will need to organize your own placement & complete the details below)

Site name:...Volunteer hours per week...

Date starting volunteer work:..

Name of Supervising Registered Physiotherapist (PT) ....

Contact Number for PT Work..................................... Mobile...

ALL applicants

What do you want to gain from this training?

....

....

Signature: .... Date: ....

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