**WESTERN STUDENT CONNECTIONS WORKSHOP EXPRESSION OF INTEREST**

**CALM SUICIDE PREVENTION 6-HOUR WORKSHOP**

**EMAIL TO:** [**reception@wsc.edu.au**](mailto:reception@wsc.edu.au) **FAX TO: 02 6885 6199**

**Section 1 Course Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Course Name: | **CALM Suicide Prevention Workshop** | | |
| 2. Date and Venue: | |  |  | | --- | --- | |  | **Dates and Venues to be advised following EOI round** | | | |
| 3. Participant Name: |  | | |
| 4. Current Workplace: |  |  |  |
| 6. Position: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**Section 2 Personal Details:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 7. Preferred Name: |  | | | |
| 8. Residential Address: |  | | | |
| Town: |  | | Postcode: |  |
| 9. Contact Details: | Phone: |  | Mobile: |  |
|  | Email: |  | | |
| 10. Gender: | 🞏 Male 🞏 Female | | | |

**Section 3 Other Information:**

|  |
| --- |
| 11. Are you of Aboriginal or Torres Strait Islander origin? 🞏 No  🞏 Yes, Aboriginal 🞏 Yes, Torres Strait Islander |
| 12. Do you consider yourself to have a disability, impairment, or long-term condition? 🞏 No 🞏 Yes |
| *If yes, mark any applicable box:* |
| 🞏 Vision 🞏 Hearing / Deaf 🞏 Physical 🞏 Intellectual 🞏 Medical Condition 🞏 Mental Illness  🞏 Acquired Brain Impairment 🞏 Learning 🞏 Other |
| 13. Do you require assistance because of this disability, impairment or long-term condition? 🞏 No 🞏 Yes |
| *If Yes, please contact Western Student Connections* |

**Section 4 Declaration:**

🞏 I understand that this is an EOI round to determine interest and venues for workshops

🞏 I will be contacted by WSC as soon as venues and dates are set

🞏 Workshop cost is $275.00 (incl. GST) per participant, and will be required prior to attendance at the workshop

🞏 Completing this workshop entitles me to the Early Bird discounted rate of $235.00

**A tax invoice is to be made out to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dietary requirements:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_