

# Accredited Training SOO Enrolment Form



ABN: 93 621 286 928

## Personal Details

|  |  |                   |   |
|--|--|-------------------|---|
| Enrolment Name (as it will appear on your qualification)<br>First Name(s): |  | Surname:          |   |
| Preferred Name:  |  | Date of Birth:    | Male <input type="checkbox"/> Female <input type="checkbox"/> |
| Postal Address:  |  |                   |   |
| Suburb:  |  |                   | Post Code:  |
| Telephone: (    )  |  | Mobile:           |   |
| Email: <i>please print clearly</i>   |  |                   |   |
| Employer Name:   |  | Position:         |   |
| Site Address:  |  |                   |   |
| Suburb:  |  |                   | Post Code:  |
| Telephone: (    )  |  | Facsimile: (    ) |   |
| Email: <i>please print clearly</i>   |  |                   |   |
| Supervisor Name:   |  |                   |   |

## Training Course Details & Information

|  |   |
|--|---|
| Enter details on the training course you wish to enroll in (which may be either a Qualification, Course, Unit/s or Subject/s)  |   |
| Code (if known):<br><b>MSL40109</b>  | Course/Unit/Subject Name:<br><b>Cert IV Laboratory Techniques (Education)</b><br><input type="checkbox"/> General<br><input type="checkbox"/> Biology<br><input type="checkbox"/> Chemistry |
| Training Commencement Date (if known):   | Location:   |
| Do you require further information about the course content and vocational outcomes? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Please tick</i>   |   |
| Will you apply for Recognition of Prior Learning (RPL) for all or part of this training?<br><i>(Note: for RPL, a separate application is required)</i> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Please tick</i> |   |
| Please contact our Training staff to discuss any access and equity issues you may have eg: a) Language, Literacy or Numeracy, b) health or disability, c) cultural issues. If you are unsure, please call.                         |   |
| Your Signature:  |   |

Please return your completed registration form to:

Symbio Alliance  
Consulting & Training Division  
PO Box 4312  
Eight Mile Plains Q 4113      Fax: (07) 3340 5796

### Office Use Only

| BDM Manager<br>(if applicable) | Training<br>Co-ordinator | Entered into<br>Database | Course<br>Code | Course<br>ID | Invoiced |
|--------------------------------|--------------------------|--------------------------|----------------|--------------|----------|
| JB                             |                          |                          |                |              |          |



# Training Enrolment Form

The following information is collected for government statistical purposes only.

**EMPLOYMENT:** tick  *one box* Are you employed: Full Time  or Part-time

**SCHOOLING:** tick  *one box* Are you still at school: Yes  No

What is your highest COMPLETED school level: Year 12  11  10  9 or equivalent  8 or below  did not go to school

In which YEAR did you complete that school level? Please write in the box.

Name of school \_\_\_\_\_ Suburb of school \_\_\_\_\_

Learner Unique Identifier (provided to you in grade 10) \_\_\_\_\_

## PRIOR EDUCATIONAL ACHIEVEMENTS:

Since leaving school have you COMPLETED any tertiary qualifications? Yes  No

If YES, then tick  *ANY applicable boxes:*

Certificate I  Certificate II  Certificate III  Certificate IV  Diploma

Advanced Diploma or Associate Degree  Bachelor Degree or Higher Degree Level

Miscellaneous Education (*please specify*): \_\_\_\_\_

## PLACE OF BIRTH:

Were you born in Australia? Yes  No  If NO, which country were you born in? \_\_\_\_\_

Please tick  *if you are:* of Aboriginal  or Torres Strait Islander  Origin?

## LANGUAGE:

Do you speak a language OTHER THAN ENGLISH at home? Yes  No

If YES please specify the MAIN language spoken at home. \_\_\_\_\_

How well do you speak ENGLISH? Tick  *one box:* Very Well  Well  Not Well  Not Very Well

## MEDICAL CONDITION/DISABILITY:

Do you consider you have a permanent and significant disability? Yes  No

If YES, then tick *ANY applicable boxes*

Vision  Intellectual  Hearing/Deaf  Mental Illness  Physical  Learning

Medical Condition  Unspecified  Acquired Brain Impairment  Other: \_\_\_\_\_

## STUDY REASON: Tick ONLY *one box:*

Which BEST describes your main reason for undertaking this training program?

To get a job  To develop my existing business  To start my own business

To try for a different career  To get a better job or promotion  It was a requirement of my job

I wanted extra skills for my job  To get into another course of study  For personal interest or self development  Other reasons

## STUDENT SIGNATURE/DATE:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_