

## Centre for Clinical Interventions

## • Psychological therapy • Research • Training • Resources

# Workshop Registration Form 2021

**All fields need to be filled in order for your registration to be processed.**

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| **Workshop title:** |  | |
| **Workshop date:** |  | |
| **Name**: |  | |
| **Organisation**: |  | |
| **Position**: |  | |
| **Postal address**: |  | |
| **Work email:** |  | |
| **Personal email:** |  | |
| **Contact telephone number/s**: | | **Fax**: |
| **# Please inform us as soon as possible if your work/contact details have changed since registration, prior to the workshop.** | | |

**NB: Prior to submission of this registration form***, please note the following:*

* Submitting a registration form **does not guarantee you a place in the workshop.** All registrations received will be acknowledged by email.
* A **separate enrolment form is required** for each workshop and each participant.
* If you are travelling from rural WA or interstate, please **do not book flights or accommodation** until you have a confirmed place in our workshop.
* **The ‘advanced’ workshops require prior training in CBT**. Please indicate your training and experience using CBT on p3 of this form; otherwise you may be contacted to provide further information and this may delay the processing of your application.

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| **Payment: 1 day workshop: $160.00** (incl. GST)  **2 day workshop: $286.00** (incl. GST)  Payment Policy: Once a place is offered, payment is required immediately to confirm your place. If prompt payment is not received we reserve the right to cancel your registration.   * **For GST purposes, this document will be a Tax Invoice upon payment.**  (NMHS ABN: 61 282 636 952) * Cancellation Policy: All cancellations must be notified in writing. Cancellations received one week prior to workshop will be refunded in full. If you cannot attend, your registration is transferable to another member of your organisation. |

### **Payment options: *Credit Card* OR *Cost Centre transfer* only**

**\*\* Your registration will not be processed if this section or the next is incomplete.\*\***

* If paying by **Credit Card**, please complete the following information:
  + - *Please note: Department of Health “Purchase Cards” will* ***not be accepted*** *for payments.*

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| **TYPE OF CARD:** |  |  | MASTERCARD |  | VISA CARD |

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| **AMOUNT:** | $ |  |  |  | . |  |  |

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| **NAME ON CARD:** |  | **CVV:** |  |  |  |

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| **CARD NUMBER**: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **SIGNATURE:** |  | **EXPIRY DATE**: |  |  | **/** |  |  |

### **Payment options** *(continued):*

* If paying by **Cost Centre transfer** *(if you are from within the Department of Health in Western Australia*) – please complete the following information:

|  |  |  |
| --- | --- | --- |
| **Please debit the total amount due:** $   .00 from the following: | | |
| Health Service/Hospital Name: |  |  |
| Authorising officer name: |  |  |
| Authorising officer’s HE Number: |  |  |
| Cost Centre Number: |  |  |
| Contact telephone number: |  |  |
| **Authorising officer**’s signature: |  |  |

**\*\* PLEASE COMPLETE ALL SECTIONS\*\***

## Participant Background Information

We would like to know a little about the people who are interested in attending our training.

***Please fill in the information on page 3 as well – if not filled in, we may have to contact you to seek extra information particularly for the advanced workshops, and this may delay the processing of your registration.***

*Thank you for assisting us by completing these questions.*

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| **Name of Registrant**: |  |
| **Place of Employment**: |  |

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| East Metro, DOH | North Metro, DOH | South Metro, DOH | WACHS, DOH | Women’s/ Children, DOH | Other | Private |

**Profession and training**:

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| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| Clinical Psychologist | Nurse | Occupational Therapist | Doctor/ Psychiatrist | Social Worker | Psychologist | Counsellor |

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| Other profession (please specify): | | |  |
| Qualifications: |  | | |
| Years post qualification: | |  | |

**\*\* PLEASE COMPLETE ALL SECTIONS\*\***

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| **1.** | **Please describe briefly your previous experience with CBT:** | | | | | | |  |
|  | None | | | | | | |  |
|  | CCI Foundation Course. Please specify year: | | | | | |  | |
|  | Other CCI Training Course(s); Please specify course and year: | | | | | | |  |
|  | |  | | | | | | |
|  | Reading and/or studying | | |  | | | | |
|  | Formal training: Facilitator: | | |  | | | | |
|  | Course and year: | |  | | | | | |
|  | Formal supervision: Name of Supervisor: | | | | |  | | |
|  | Length and frequency of supervision: | | | |  | | | |

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| **2.** | **What is your current caseload of ongoing psychotherapy clients?** | | | |  |
| **3.** | **What CBT techniques do you currently use with your clients?** | | |  | |
|  | |  | | | |
|  | |  | | | |
|  | |  | | | |
| **4.** | **What do you expect to get out of attending this training?** | |  | | |
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| **Please** send **all pages** via **post**, **fax**,or, **save and email** to:  Administrative Assistant Centre for Clinical Interventions 223 James Street, Northbridge WA 6003  **Fax:** (08) **9328 5911**  **Email: info.cci@health.wa.gov.au** |

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| **For further information, please contact**  Alice Martins (Administrative Assistant), or  Dr Adelln Sng (Training Coordinator)  **Centre for Clinical Interventions**  **Psychological TherapyResearchTrainingResources**  223 James Street, Northbridge Western Australia 6003  **T**: +61 8 9227 4399 **|** **F**: +61 8 9328 5911  **E**: [info.cci@health.wa.gov.au](mailto:info.cci@health.wa.gov.au)  **W**: <http://www.cci.health.wa.gov.au/> |