

CHRONIC DISEASE SELF MANAGEMENT PROGRAM (CDSMP) APPLICATION FORM

I wish to attend:

- Leader Training: Monday to Thursday 4-7 October 2010 \$830
 I would also like to purchase the "Arthritis Help Book" \$45

Name: _____

Discipline: _____

Current Occupation: _____

Organisation: (if appropriate): _____

Postal Address: Business address Home address (if lay leader)

Postcode: _____

Contact Telephone Numbers

Business: _____ Home: _____ Mobile: _____

Fax: _____ Email: _____

Previous Experience with the CDSMP:

- I have no previous experience with the CDSMP I have attended a Community Course

State the nature of your chronic condition if you have one: _____

Do you have any special needs, eg: wheelchair access? _____

Dietary Requests: Vegetarian Diabetic Other (please specify) _____

Is your organisation licensed? YES NO

If 'NO' have you contacted Stanford re obtaining a licence? YES NO

Name of Contact Person for licence in your Organisation: _____

Contact person's email: _____

ENCLOSED PLEASE FIND MY (Payments will not be processed until two weeks before the course)

Cheque Money Order Cash to the value of _____

Or please debit my Mastercard Visa American Express

Credit Card No: _____ Expiry Date: ____ / ____

Cardholder Name: _____

Signature: _____ Date: _____

Please send your completed application form and course fee to

Arthritis Queensland

PO Box 2121, Windsor QLD 4030

Phone: (07) 3857 4200 Fax: (07) 3857 4099.