

ENROLMENT FORM

Queensland Government Certificate 3 Guarantee Program

Please complete in Block Capitals

Please return via email info@csf.edu.au

QUALIFICATION CODE QUALIFICATION TITLE
COURSE START DATE / /

APPLICANT

Mr / Mrs / Ms / Miss (circle) Male / Female (circle) Date of Birth / /
First Name Middle Name Surname
Home Address
Suburb State Postcode
Home Phone () Mobile Email

EMPLOYMENT STATUS

☐ Self-employed (not employing others) ☐ Full-time employee ☐ Part-time employee
☐ Employer (unpaid worker in a family business) ☐ Unemployed (seeking full-time work) ☐ Employer
☐ Unemployed (seeking part-time work) ☐ Not employed (not seeking employment) ☐ At school
Workplace Coach/Supervisor
Employer (Trading Name)
Workplace Street Address
Suburb State Postcode
Workplace Postal Address: ☐ as above
Suburb State Postcode
Work Phone () Work Fax () Email

EDUCATION

What is your highest school year level completed?
☐ Did not go to school ☐ Year 8 or below ☐ Year 9 or equivalent ☐ Year 10 ☐ Year 11 ☐ Year 12
What year did you complete that level? [eg. 1999]
Have you successfully completed any of the following qualifications? ☐ No ☐ Yes (please specify)
Name of Qualification Year Completed
☐ Certificate Level I ☐ Certificate Level II ☐ Certificate Level III ☐ Certificate Level IV
☐ Diploma ☐ Bachelor or Higher Degree ☐ Advanced/Associate Degree ☐ Miscellaneous Education
Are you currently studying? ☐ No ☐ Yes (please specify)

Citizenship ☐ Australian Citizen or Permanent Resident and permanently residing in Queensland
☐ New Zealand citizen permanently residing in Queensland
☐ Other

Country of Birth

Are you of Aboriginal or Torres Strait Islander origin? ☐ No ☐ Aboriginal ☐ Torres Strait Islander

Which language do you mainly speak at home? ☐ English ☐ Other (please specify)

How well do you speak English? ☐ Very well ☐ Well ☐ Not well ☐ Not very well

Do you consider yourself to have a disability, impairment or long-term condition? ☐ No ☐ Yes (please specify)

☐ Vision/Sight ☐ Hearing/deaf ☐ Physical ☐ Intellectual
☐ Mental illness ☐ Learning ☐ Medical illness ☐ Acquired Brain Impairment

Do you hold a current Health care Card or Pensioner Card, or are the partner or dependant of a Healthcare Card/Pension Card holder and are named on the card. (A copy of the card is required) ☐ No ☐ Yes

I declare that the information provided above is true and correct. By enrolling in this training program, I hereby give consent for any information collected to be used for research, statistical analysis, program evaluation and internal management. I understand that this information can be shared with the relevant state funding authority (where applicable). I understand that I will no longer be eligible for a subsidised training place under the Queensland Certificate 3 Guarantee Program once I complete this qualification. I understand that it is a requirement of the program that I complete and return a Training and Employment Survey within 3 months after training.

SIGNATURE DATE / /

CSF0054 RTO 91345 / CRICOS Number 03057C