



## APPLICATION TO ATTEND AN ADULT TRAINING COURSE

Applications must be received at Branch Head Quarters **3 WEEKS** prior to commencement date of all courses,  
except Leader Advanced Skills, which close **4 WEEKS** prior to commencement date

### PERSONAL DETAILS

Family or Surname	First Name(s)	Member No.
Middle Name(s)		Preferred Name
Group / Formation	Section	Position / Appointment
Postal Address		
Suburb/ Town		P/Code
Home Phone	Work Phone	Mobile Phone
Email Address		

### COURSE DETAILS (Individual Forms to be submitted for each course)

	Section	Location	Start Date	Cost
<b>Scouting Essentials</b>				
<b>Leader Skills</b> <small>usually 2-weekend OR 1 long weekend duration.</small>				
<b>Leader Advanced Skills</b> <small>usually 3-weekend OR 6 continuous Days duration.</small>				
<b>Adventurous Activity</b> <small>Please Specify Type</small>				
<b>Leader Elective / Other</b> <small>Please Specify Type</small>				
<b>Training Aids</b>				
<b>Training Methods</b>				
<b>Personal Leader Advisor</b>				
<b>Potential Assist Leader Trainers</b>				

### PAYMENT (Must accompany each application)

<b>1. CHEQUE</b>				
Drawer:	Bank:	Cheque Number	\$	
<b>2. CASH</b>				
\$				
<b>3. ELECTRONIC FUNDS TRANSFER</b>				
<small>Please circle card type</small>				
		Bank Card	Master Card	Visa
Card Number	Last Three Numbers of the Identification Number <small>(Top of rear side of card)</small>			
Card Holders Name	Expiry Date	\$		
<b>4. DIRECT PAYMENT</b> <small>Please include <b>TRAINEES</b> surname in payment details</small>				
Bank: <b>WESTPAC</b>	BSB: <b>036 011</b>	Account No: <b>82 1220</b>	\$	

<b>Head Office Use Only</b>	Account Code <b>TRG</b>	Course Code	Receipt Number
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### ENDORSEMENT (Applications must go through District)

	Print Name	Signature	Date Received	Date Forwarded
<b>Applicant:</b>				
<b>Group Leader:</b> <small>'I verify ALL Applicant's details are correct on SCOUTRAK'</small>				
<b>District Adult Resources:</b>				
<b>Branch Head Quarters:</b>				

## HEALTH STATEMENT (All areas *must* be completed)

Does the applicant suffer any of the following?	Please tick		If <b>Yes</b> , please detail in full. Where medication is being administered include names of drugs and frequency of administration. If insufficient room please attach separate page.
	No	Yes	
Allergy - Drug			
Allergy - Food			
Allergy - Insect			
Allergy - Other			
Asthma			
Diabetes			
Epilepsy			
Heart Condition			
Migraine			
Sleepwalking			
Intellectual Disability			
Physical Disability			
Other			
Other			
Other			

Does the applicant take any medication, tablets and prescription drugs or use any form of aid?	Please circle	
If <b>Yes</b> please detail:	Yes	No

Does the applicant wear or carry a Medic Alert bracelet, charm or card?	Please circle	
If <b>Yes</b> please detail:	Yes	No

Does the applicant have any special dietary requirements for medical, spiritual or other reasons?	Please circle	
If <b>Yes</b> please detail:	Yes	No

Has the applicant been immunized for Tetanus in the past 5 years?	Please circle	
If <b>No</b> , can the applicant be given a Tetanus injection should the need arise?	Yes	No

## HEALTH FUND DETAILS

Medicare No:	Health Fund:
Ambulance Fund No:	Health Fund No:

## EMERGENCY CONTACT

Family or Surname	First Name(s)	Relationship To Applicant
Residential Address		
Suburb/Town		P/Code
Home Phone	Work Phone	Mobile
Email Address		