

PSYCHOSOCIAL GROUPS PROGRAM



ENROLLMENT FORM

Participant Details			
Name			
Postal Address			Postcode
Telephone Number			
DOB	day / month / 19 year	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Referrer Details (if applicable)			
Organisation			
Postal Address			Postcode
Telephone Number	Fax Number		
Name of Referrer			
Group and location preference			
Safety issues			
Are there any current safety issues?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If YES, please give details below
Participant/Referrer Comments			
Participant signature		Referrer signature (if applicable)	
Date	day / month / 20 year		

Please return to
Mental Illness Fellowship of SA Inc
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