

WHSCT Recovery College Enrolment Form

Title (Mr/Mrs/Miss/Ms): _____

Forename: _____

Surname: _____

Address: _____

Town: _____ PostCode: _____

Telephone No: _____

Mobile No: _____

Email: _____

Date of Birth: _____

Gender (Please Tick): Male Female Non-defined

Please indicate your preferred method of contact (Please tick):

Email Mobile Post

WHICH COURSES DO YOU WISH TO ATTEND

Course	Date



WHSCOT Recovery College Enrolment Form

PLEASE TELL US WHETHER YOU ARE (Please tick):

Person with Lived Experience:

Health Professional:

Private Sector Staff:

Public Sector Staff:

Community Voluntary Staff:

Carer (including family & friends):

Prefer not to say:

HOW DID YOU HEAR ABOUT THE RECOVERY COLLEGE (Please Tick):

GP:

Health Professional:

Community/Voluntary Service:

Social Media:

Family/Friends:

Leaflet/Poster /Prospectus:

Please also let us know if there any reasonable adjustments (i.e. disability related) required in facilitating your attendance. We will make every effort to support your needs.

PLEASE NOTE: Under the GDPR Legislation, May 2018, by enrolling with the WHSCOT Recovery College you are agreeing to us holding your personal information. It will be securely disposed of after ten years and not used for any other reason other than for the purpose of running the College.

Signature: _____ Date: _____

