

## Responsive Behaviours Master Class – Wednesday 22 May 9am to 1.30pm

Please complete all the sections below

<b>Family Name:</b>	<b>Given Name:</b>
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<b>Email:</b>
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<b>Contact Telephone:</b>	<b>Mobile:</b>
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<b>City/Town:</b>	<b>State:</b>	<b>Postcode:</b>
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<b>Work Setting (Tick only one):</b>					
<b>Acute Care</b>	<input type="checkbox"/>	<b>Residential Care</b>	<input type="checkbox"/>	<b>Primary or Community</b>	<input type="checkbox"/>
<b>Transition</b>	<input type="checkbox"/>	<b>Multiple Care Settings</b>	<input type="checkbox"/>	<b>Tertiary Education</b>	<input type="checkbox"/>
<b>Other (please specify):</b>					<input type="checkbox"/>

<b>Employer or Study Organisation:</b>
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<b>Occupation or Area of Study (Tick only one):</b>					
<b>Assistant In Nursing</b>	<input type="checkbox"/>	<b>Facility Manager</b>	<input type="checkbox"/>	<b>Physiotherapist</b>	<input type="checkbox"/>
<b>Clinical Nurse</b>	<input type="checkbox"/>	<b>General Practitioner</b>	<input type="checkbox"/>	<b>Psychiatrist</b>	<input type="checkbox"/>
<b>Clinical Nurse Coordinator</b>	<input type="checkbox"/>	<b>Geriatrician</b>	<input type="checkbox"/>	<b>Psychologist</b>	<input type="checkbox"/>
<b>Dietician/ Nutritionist</b>	<input type="checkbox"/>	<b>Manager</b>	<input type="checkbox"/>	<b>Registered Nurse</b>	<input type="checkbox"/>
<b>Diversional Therapist</b>	<input type="checkbox"/>	<b>Medical Specialist</b>	<input type="checkbox"/>	<b>Social Worker</b>	<input type="checkbox"/>
<b>Director Of Nursing</b>	<input type="checkbox"/>	<b>Nurse Practitioner</b>	<input type="checkbox"/>	<b>Student</b>	<input type="checkbox"/>
<b>Educator / Teacher / Trainer</b>	<input type="checkbox"/>	<b>Nurse Unit Manager</b>	<input type="checkbox"/>	<b>Team Leader</b>	<input type="checkbox"/>
<b>Enrolled Nurse</b>	<input type="checkbox"/>	<b>Occupational Therapist</b>	<input type="checkbox"/>	<b>Volunteer</b>	<input type="checkbox"/>
<b>Endorsed Enrolled Nurse</b>	<input type="checkbox"/>	<b>Personal Care Worker</b>	<input type="checkbox"/>	<b>Other</b>	<input type="checkbox"/>

<b>Dietary Requirements: (Tick all that apply)</b>					
<b>No Special Requirements</b>	<input type="checkbox"/>	<b>Vegetarian</b>	<input type="checkbox"/>	<b>Vegan</b>	<input type="checkbox"/>
<b>Gluten Free</b>	<input type="checkbox"/>	<b>Lactose Free</b>	<input type="checkbox"/>		<input type="checkbox"/>
<b>Other (please specify):</b>					