

# COURSE BOOKING FORM



## PERSONAL DETAILS

First Name(s)*	<input type="text"/>	Title*	<input type="text"/>
Last Name*	<input type="text"/>	Gender*	<input type="text"/>
Date of Birth* (DD/MM/YYYY)	<input type="text"/>	I confirm I am 18 years or over*	
Ethnicity*	<input type="text"/>		

## CONTACT INFO

Email*	<input type="text"/>				
Phone*	Mobile*	<input type="text"/>	Home*	<input type="text"/>	
Address 1*	<input type="text"/>				
Address 2*	<input type="text"/>				
City/Town*	<input type="text"/>			County*	<input type="text"/>
Postcode*	<input type="text"/>				
What is the name of your General Practice (GP)?*	<input type="text"/>				
GP Surgery Tel Number*	<input type="text"/>				
Is there anything else you think we should know about your mental health?	<input type="text"/>				

Please tick all that apply\*

FRONTLINE STAFF	OVER 55	CARER	LGBTQI	MANUAL WORKER	NONE OF THESE
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## COURSE DETAILS

How did you hear about us?*	<input type="text"/>				
Course 1 Title*	<input type="text"/>				
Course Start Date*	<input type="text"/>				
What would you like to achieve from this session?*	<input type="text"/>				
Would you like support accessing any sessions? *	NO	YES	If YES, please describe what support you would require:	<input type="text"/>	

## COURSE DETAILS

Course 2 Title	<input type="text"/>				
Course Start Date	<input type="text"/>				
What would you like to achieve from this session?	<input type="text"/>				

Please complete all fields marked with an asterisk. Please contact us if you have any difficulty filling out this form. We recommend you save a copy of your form before you send it by email.

**PLEASE EMAIL COMPLETED FORM TO: [RedhillCC@RichmondFellowship.org.uk](mailto:RedhillCC@RichmondFellowship.org.uk)**

Richmond Fellowship ● East Surrey Community Connections ● Wingfield, St Anne's Drive, Redhill, Surrey RH1 1AU

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