

Relationship Workshop (2RW-10): Application Form

****Participants should join as a group (2 persons or more). (Your partners can be your close friends, spouse, siblings, family members or someone having intimate relationship with you.)

Family Group: Applicable to group with immediate members of family; e.g. parents and children, siblings.

Office Use:
Group _____

	Participant 1	Participant 2
Name of Participant:	(Chi): _____ (Eng): _____	(Chi): _____ (Eng): _____
Member Code:		
Sex/ Age/ Occupation:	Sex: _____ Age: _____ Occupation: _____	Sex: _____ Age: _____ Occupation: _____
Correspondence Address:		
Contact:	Tel: _____ Fax: _____ E-mail: _____	Tel: _____ Fax: _____ E-mail: _____
Satir Workshop Experience (Name/Trainer/Year/No. of Days)	Name of Workshop: _____ No. of Days: _____ Name of Trainer: _____ Year of Workshop: _____	Name of Workshop: _____ No. of Days: _____ Name of Trainer: _____ Year of Workshop: _____
Name Appearing on Certificate:		
Contact Person for Emergency (Name/Tel):		
Chronic Illness (if applicable)	Please specify:	Please specify:
	I have/have not attended regular treatment. (please cross as inappropriate)	I have/have not attended regular treatment. (please cross as inappropriate)
	I have been assessed/not been assessed by professionals that I am physically/mentally/psychologically fit/not fit to attend this workshop. (please cross as inappropriate)	I have been assessed/not been assessed by professionals that I am physically/mentally/psychologically fit/not fit to attend this workshop. (please cross as inappropriate)

Total Amount: HK\$	Cheque no: _____/_____	Signature: _____	Date: _____
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Declaration

1. I understand the above personal data are collected for registration purpose only. I have the right of access & correction with written request in accordance with the provisions of the Personal Data (Privacy) Ordinance.
2. I understand that the workshop is of educational but not therapeutic nature. In the process of self-exploration, I understand that I may be triggered emotionally or psychologically. In case of need, I would take the initiative to seek for the counseling service by the Center or help from other professional bodies.
3. I have sought the view of concerned counselor/medical worker/professionals, who have confirmed that I am fit to attend this course physically & psychologically.
4. I have read this brochure. I understand and agree to the registration & refund arrangement.

Signature of Applicant _____ Date _____

OFFICE USE

Amount: <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$3,900	<input type="checkbox"/> \$4,400 <input type="checkbox"/> \$4,900	Cheque no: _____	Receipt # T _____	Staff: _____	Date: _____	Remarks: _____
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Enquiries

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