

2014 Trainee Application Form

Please print clearly in English and BLOCK letters. Tick boxes where appropriate. ☒

Section 1: Trainee Details

Personal Information

Title: Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Other <input type="text"/>	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
First Name <input type="text"/>	Surname <input type="text"/>
Other Names <input type="text"/>	Date of Birth (day/month/year) <input type="text"/>

Contact Details

Mobile Telephone <input type="text"/>	Business Telephone <input type="text"/>
Email <input type="text"/>	
Residential Address <input type="text"/>	
Suburb <input type="text"/>	Postcode <input type="text"/>
Postal Address (if different to above) <input type="text"/>	
Suburb <input type="text"/>	Postcode <input type="text"/>
Home Telephone <input type="text"/>	Mobile Telephone <input type="text"/>

Citizenship and Residence status

Are you of Aboriginal or Torres Strait origin?	No <input type="checkbox"/>	Yes, Aboriginal <input type="checkbox"/>	Yes, Torres Strait <input type="checkbox"/>
In which country were you born?	Australia <input type="checkbox"/>	Other (please specify) <input type="text"/>	
Citizenship:	Australian Citizen or permanent resident <input type="checkbox"/>	Other (please specify) <input type="text"/>	

NOTE: If other, a copy must be submitted with this form.

Language

Do you speak a language other than English at home?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Other (please specify) <input type="text"/>
If yes, how well do you speak and read English?	Very Well <input type="checkbox"/>	Well <input type="checkbox"/>	Not Well <input type="checkbox"/> Not At All <input type="checkbox"/>

Special Requirements

Do you consider yourself to have a disability, impairment or long term condition?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
If yes, then please indicate the areas of disability, impairment or long term condition:	Hearing/Deaf <input type="checkbox"/>	Mental Illness <input type="checkbox"/>
Intellectual <input type="checkbox"/> Learning <input type="checkbox"/> Physical <input type="checkbox"/> Vision <input type="checkbox"/> Medical Condition <input type="checkbox"/>	Other (please specify) <input type="text"/>	

Section 2: Employment Details

Company <input type="text"/>	Worksite Supervisor <input type="text"/>
Work Address <input type="text"/>	
Are you an Owner, Partner or Director of the business?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Position <input type="text"/>	
Date commenced with your employer? (day/month/year) <input type="text"/>	

Section 3: Education Details

High School/Secondary Education/Senior Secondary Education

Are you still attending Secondary School?	No <input type="checkbox"/> Yes <input type="checkbox"/>	What year did you complete that school level?
Highest School Level Completed:	Completed Year 12 <input type="checkbox"/>	Completed Year 11 <input type="checkbox"/> Completed Year 10 <input type="checkbox"/>
	Completed Year 9 <input type="checkbox"/>	Completed Year 8 or lower <input type="checkbox"/> Didn't attend school <input type="checkbox"/>

Tertiary Education/Traineeship/Apprenticeship

Have you previously completed any formal qualifications (including traineeships or apprenticeships) in your current or a previous name?

No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Previous Name							
If yes, please specify:		Certificate I	<input type="checkbox"/>	Certificate II	<input type="checkbox"/>	Certificate III	<input type="checkbox"/>	Certificate IV	<input type="checkbox"/>	Diploma	<input type="checkbox"/>
		Advanced Diploma	<input type="checkbox"/>	Bachelor Degree/Graduate Studies		<input type="checkbox"/>	Other (please specify)				

What was the Name of the Qualification?	
Year Commenced	Year Completed
Have you previously completed any other Qualifications? No <input type="checkbox"/> Yes <input type="checkbox"/>	
If yes, please provide details	
Have you ever commenced a Traineeship or an Apprenticeship before? No <input type="checkbox"/> Yes <input type="checkbox"/>	
If yes, what was the name and level of the qualification?	
In which State of Australia was it undertaken?	
Are you currently undertaking any other study? No <input type="checkbox"/> Yes <input type="checkbox"/>	
If yes, what is the name of the qualification you are studying?	

Proposed Qualification

--

Declarations

Trainee Declaration

I Full Name I declare that the information provided by me on this form is true and correct and I understand that this information will be treated as private and confidential and will not be divulged without my written consent except where Study Group Australia is legally obliged to do so. I understand that Study Group Australia is required to provide the Government with student and training activity data which may include information I provide in this enrolment form. Information is required to be provided in accordance with the Student Statistical Collection Guidelines (which are available at www.skills.vic.gov.au/corporate/statistics.submit_data). The Government may use the information provided to it for planning, administration, policy development, program evaluation, communication resource allocation, reporting and or research activities. For these and other lawful purposes the Government may also disclose information to its consultants, advisers, other government agencies, professional bodies and or other organisations. I authorise the training representative from Study Group Australia to discuss my training program development and/or view appropriate evidence with my employer/supervisor/trainer. I acknowledge and agree to the terms described in this privacy statement.

Authority to view documents (Privacy Act 1988 (Cth) and Information Privacy Act (VIC) 2000). During your training there may be situations that will require a Study Group Australia trainer/assessor to discuss your progress with an appropriate workplace representative. Also there will be the need to examine workplace samples for the purpose of assessment. All discussion will be strictly confidential.

Student Signature	Date (day/month/year)
Parent/Legal Guardian* Signature	Date (day/month/year)

*if applicant is under the age of 18

Employer (or Employer Representative) Declaration

I Full Name of Company Name
authorise the training representative from CLB Training to view applicable documents and/or speak to the workplace supervisor and/or the mentor to discuss the trainee's progress.

Employer Signature	Date (day/month/year)
--------------------	-----------------------

CLB Representative

Full Name	
Study Group Representative Signature	Date (day/month/year)

Study Group Staff Use Only

Please tick the applicable option(s) below

Funding	Fees for Service	<input type="checkbox"/>	Victorian Training Guarantee	<input type="checkbox"/>	Skills for Growth (VIC Only)	<input type="checkbox"/>	Interstate U/C	<input type="checkbox"/>
AAC Eligibility Result	Commencement and Completion	<input type="checkbox"/>	Re-commencement and Completion	<input type="checkbox"/>	Completion Only	<input type="checkbox"/>	Ineligible (Client Approval Attached)	<input type="checkbox"/>
Fees	Enrolment: \$	<input type="text"/>	Commencement: \$	<input type="text"/>	Completion: \$	<input type="text"/>		

Additional Information

Workplace Based	<input type="checkbox"/>	If so, please list two preferred training locations	1 <input type="text"/>
Classroom Based	<input type="checkbox"/>		2 <input type="text"/>
AAC Sign Up Required	<input type="checkbox"/>	Scheduled/Completed Date	<input type="text"/>
		AAC Name	<input type="text"/>
		Representative Name	<input type="text"/>

TRAINING ADMINISTRATION TO COMPLETE

VETtrak Number	<input type="text"/>
Trainer	<input type="text"/>
Administrator	<input type="text"/>
Contract Value \$	<input type="text"/>
VETtrak Number	<input type="text"/>
Trainer	<input type="text"/>
Special Notes	<input type="text"/>
Referred by Study Group Representative	<input type="text"/>