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**Cygnet for practitioners**

**A 2 day training programme for professionals working with children and young people aged 5-18 and their families with a diagnosis of an Autistic Spectrum Condition.**

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| CYGNET for practitioners trainingEnrolment form | | | |
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| Course attendee BASIC INFORMATION **Please complete if you are wanting an individual place or if you are representing a service for group delivery request.** | | | |
| **Name:** | **Email:** | | **Phone No:** |
| **Job Title:** | **Based at:** | | **Area of Lancashire you deliver your service in:** |
| **Please describe your connection to children / young people and their families and how this course would benefit your area of work.** | | | |
| **If completing on behalf of your organisation for a group course delivery** | | | |
| **Number of attendees for the course** | |  | |
| **Which service do you represent?** | |  | |
| **Who does your service support?** | |  | |
| **Do you have a disability or is there additional Information you want to provide to help you attend a group: (i.e. access to a lift, literacy support)?** | | | |

**I have been provided with written information about the service and have had explained:**

* **what information they will collect, why and what they will use the information for;**
* **that the records may be kept in paper files or on electronic systems and may include photographs, videos and other personal information;**
* **That information will be held in confidence and the limits to confidentiality.**
* **The programme coordinator has encouraged me to raise questions and concerns at any stage whilst we work together.**

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| **North Lancashire Directions Group & Morecambe Bay Hospitals**  **CYGNET FOR PRACTITIONERS** | | | |
| **Dates for training – To be confirmed** | | | |
| **Day One** |  | **Day Two** |  |

**I agree to the programme coordinators processing information about my organisation in order to provide the services.**

**I understand I may review this consent at any time. Please sign if you are happy for us to keep your details on our system.**

**Completion of this form is not a guarantee of a place on the training. Confirmation of your place will be sent via post/email prior to the start date.**

**Course fees must be paid within 60 days of training completion.**

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| **Signed** | **Date** |

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| admin use | |
| Date entered on Programme List: | Received via: |
| Programme Information Leaflet Sent Yes No  Privacy Notice Sent Yes No | DPA Consent Received Yes / No  Date received: |
| Invoice sent via | Invoice paid : |
| **Sign Off: Cygnet Co-ordinator**  Signed:………………………………………………………………  Date:………………………………………………………………..  Place allocated YES NO  Course block allocated  Details passed to CFP trainers | |
| Please return to:  Lucy Ellis (Cygnet Coordinator)  Barnardo’s Cygnet Programme  c/o Lune Park Children’s Centre  Owen Road  Lancaster  LA1 2LN  Tel: 07873818153  Email: cygnetsnorthlancs@gmail.com | |



