[Course name]

Expression of Interest

Surname:_____

First Name:_____(Mr/Mrs/Miss)

Name Used (if different from above):_____

Address:_____

_____

Phone No:_____

Date of Birth:_____/_____/_____

Date Joined:_____

Next of Kin: (In case of emergency):_____

Relationship (Son/Daughter etc):_____

Phone No:_____

Do you consent to your Photograph being taken for advertising and social media purposes?

YES/NO

Do you consent to a medical practitioner, hospital or ambulance service to be contacted if required on the day of attendance at the group?

YES/NO