



The Flower School Pty Ltd - Enrolment Form

Today's Date ____/____/____

Student ID _____

Personal Details (legal name as shown on passport or driver's license)	
Unique Student Identifier (USI): _ _ _ _ _ If you do not currently have a USI you will be required to create one. Go to www.usi.gov.au and follow the instructions to create your USI – This is MANDATORY	
Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Other:	
First Name:	Surname:
Other Name/s:	<small>All previous or other names by which you are known or have been formerly known must be listed</small>
Residential Address:	Postcode:
Home Phone:	
Mobile Phone:	
Emergency Contact Name:	Number:
Email:	
Date of Birth: ___ / ___ / ___ (Day/Month/Year)	
<input type="checkbox"/> Male <input type="checkbox"/> Female	

Course of Study (tick box below) and Commencement Date	ONLY TICK ONE BOX
Course: Certificate II in Floristry <input type="checkbox"/> Certificate III in Floristry <input type="checkbox"/> Certificate IV in Floristry <input type="checkbox"/>	
Date of Course:	
Reason for doing course: (ONLY TICK ONE BOX)	
<input type="checkbox"/> To get a job	
<input type="checkbox"/> To develop my existing business	
<input type="checkbox"/> To start my own business	
<input type="checkbox"/> To try for a different career	
<input type="checkbox"/> For personal interest or self-development	
<input type="checkbox"/> To get a better job or promotion	
<input type="checkbox"/> It was a requirement for my job	
<input type="checkbox"/> I wanted extra skills for my job	
<input type="checkbox"/> To get into another course of study	

Vocational Education Information
Country of Birth:
Nationality:
Are you of Aboriginal or Torres Strait Islander descent? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, which?
Language spoken at home:
How well do you speak English? <input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not well <input type="checkbox"/> Not at all
Do you require language or literacy assistance?

Special Needs
Do you have a disability, impairment or long term medical condition? <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, please indicate impairment: <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Medical <input type="checkbox"/> Learning <input type="checkbox"/> Vision
<input type="checkbox"/> Other – please advise
Do you suffer from Anxiety <input type="checkbox"/> YES/NO Depression <input type="checkbox"/> YES/NO
If yes, please discuss with us, so we can work with you

Office Admin Use Only
<input type="checkbox"/> INTERVIEW <input type="checkbox"/> Book <input type="checkbox"/> MAILING LIST <input type="checkbox"/> ADDRESS BOOK <input type="checkbox"/> LLN TEST
<input type="checkbox"/> (FF) <input type="checkbox"/> (C) <input type="checkbox"/> (S) <input type="checkbox"/> STUDENT CARD <input type="checkbox"/> STUDENT REF NUMBER

