

Health Improvement Team Learning and Development

TRAINING PROGRAMME APPLICATION FORM

•	CAPITAL LETTERS
Date of Course:	
Duration of Course	e:
First Name:	Surname:
Occupation:	
Employing Organis (e.g Bradford Hospitals Trust,	Sation: Bradford District Care Trust, Bradford & Airedale Teaching PCT)
Please specify	
Postcode	
Tel. No. (work): (mobile):	(home):
E-mail Address:	

Please complete **all** the information overleaf, including home, work & mobile telephone numbers - so that if we need to we can contact you regarding the course



Please indicate whether you have an other special needs (e.g. wheelchair a etc.)	ny specific learning support needs or ccess, hearing loop, large type
/	dentially please ring 01274 237784
Please note that lunch is not provided on a	ny of our training courses (refreshments only)
Applicant's signature:	
To the Line Manager (where appropriate) I nominate the above applicant for this course.	
Manager's Signature:	Print:

(N.B. If you no longer wish to attend, please telephone to cancel your place. Failure to notify us prior to the course may result in a charge of £20.00 being imposed)

Please return this completed form to:-

Training Administration Support Worker Tel: 01274 237784 Fax: 237454

E-mail: healthdevelopmenttraining@bradford.nhs.uk

All our course details including this application form can be viewed/printed from the following website: http://www.bradford.nhs.uk/working-with-us/studying-with-us/health-improvement-training/

Learning & Development 2nd Floor, Douglas Mill,

Bowling Old Lane, Bradford, BD5 7JR

Further application forms are available from the above or please photocopy this sheet

[T/proginfo/appgen02] – Jan07