



## Appendix 1 – Registration Form Transition to Work

Fill in and sign this form with the service provider you have chosen, and who has agreed to support you.

Return the completed form to:

**E-mail:** [life.skillsandemployment@facs.nsw.gov.au](mailto:life.skillsandemployment@facs.nsw.gov.au) (scan form and attach to email)

**Mail:** Life Skills, Employment and Respite  
Ageing Disability and Home Care  
Department of Family and Community Services  
Level 2, 4 – 6 Bligh Street  
SYDNEY NSW 2000

### Your Details (The person attending the program)

First name: \_\_\_\_\_ Surname: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Phone No: \_\_\_\_\_

Postal address: \_\_\_\_\_

Name of your preferred contact person: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Phone No: \_\_\_\_\_

E-mail: \_\_\_\_\_

### Service Provider Details

Service provider name: \_\_\_\_\_

Outlet name: \_\_\_\_\_

Outlet ID (Found on outlet information page in *Choosing a Service Provider* booklet): \_\_\_\_\_

Name of contact person: \_\_\_\_\_

Outlet address: \_\_\_\_\_

Starting date: \_\_\_\_\_ Phone No: \_\_\_\_\_

E-mail: \_\_\_\_\_

### Sign here

Your or your guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of service provider\*: \_\_\_\_\_ Date: \_\_\_\_\_

\*I understand that this will result in a change to my organisation's funding and confirm that I have the authority as a Representative of my organisation to authorise funding changes.