

Application Form

Level 1 in British Sign Language



Applicant Information			
Name:		Date of birth:	
Mobile/Phone:		Email:	
Current address:			
City:		Post code:	
Deaf (BSL user) ()	Deaf (SSE user) ()	Hard of Hearing ()	Hearing ()
Emergency Contact			
Name of Contact:			
Address:			
City:		Post code:	
Phone/Mobile:		Relationship:	
Medical			
Do you have any medical conditions?		Do you have epilepsy?	
Do you have a heart condition?		Do you have any allergies?	
Are you on medication, if so, please state which one:			
Please tick if you prefer not to say:			
Disability			
Deaf or Hard of Hearing?		Unseen disability? (e.g. Diabetes)	
Physical disability?		Mental Health?	
Payment Details			
() I attach a cheque for the above amount:			
() Payment will be made to you from:		(Name of organisation)	
For more information, E-mail: admin@deafpositivesaction.org			
Authorization:			
I authorize the verification of the information provided on this from. I have received a copy of this application.			
Signature of applicant:		Date:	
Please explain why you would like to learn BSL?			