Independent Living Centre WA
Making choices finding solutions

ENQUIRY FORM

DATE: ____________ **TIME:** __________

CONTACT DETAILS **Client Type**: Family/Carer Consumer Service Provider

Title: _____ Name: ___________________________ Surname: _________________________________

Organisation:____

Position: ____

Phone: _____________________ Fax: _____________________ Mobile:________________________

Email: ____

*How did you hear about ILC MACS? ____

☐ **Regional** ☐ **Metro**

☐ **Age Group** ☐45-65 ☐65-80 ☐80 onwards

☐ **Cultural Ethnicities** _________________________ ☐ **Primary Language** _________________________

☐ **ASSISTANCE REQUIRED**

INFORMATION ON: CALD Specific: ____

☐ RACFL ☐ RACFH ☐ CLUSTER ☐ HACC ☐ CBDC ☐ RESPITE ☐ SOCIAL SUPPORT

☐ CALD STAFF ☐ INTERPRETER ☐ Meals On Wheels ☐ Health / Medications

OTHER/ DETAILS:

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MACS RESOURCES REQUEST:

_________ Brochures __________ Booklets

_________ Newsletters __________ Training Calendar ___________________Info Sheets

Other Resources: ____

☐ **TRAINING:** (***COMPLETE REGISTRATION FORM)***

☐ TRAINING NEEDS ☐ INQUIRY ☐ BOOKING ☐ PAYMENT

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For further details please contact ilcmacs@ilc.com.au