

RIDING FOR THE DISABLED ASSOC OF WA
CARINE GROUP INC
ANNUAL PARTICIPANT REGISTRATION FORM 2022



Copies of this form are kept by the Centre and the information reported for statistical purposes to Riding for Disabled Association of Australia Limited (RDAA)

1. APPLICATION FOR REGISTRATION

CENTRE: CARINE

YEAR: 2022

NEW REGISTRATION

RENEWING

2. PERSONAL DETAILS (Rider information)

TITLE: (Mr,Mrs,Ms,Miss,Dr,Rev,other)

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ POSTCODE: _____

PHONE: _____ EMAIL: _____

MALE FEMALE DATE OF BIRTH / /

AGE AS AT 1 JANUARY 2022 _____ OCCUPATION _____

EMAIL: _____

DO YOU IDENTIFY AS ABORIGINAL

TORRES STRAIT ISLANDER

3. EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

CITY: _____ STATE: _____ POSTCODE: _____

PHONE HOME: _____ MOBILE: _____ EMAIL: _____

4. FUNDING

Do you have private funding? Yes / No

Do you have NDIS funding? Yes / No

If YES to NDIS, please provide your NDIS Plan Number _____

NDIS Plan Start Date _____ NDIS Plan Review Due Date _____

Please tick responsibilities for invoicing NDIA- managed Plan managed or Self-managed

5. BILLING INFORMATION (if different from above)

NAME: _____ (Parent, Carer, School or Institution)

ADDRESS: _____

CITY: _____ STATE: _____ POSTCODE: _____

PHONE: _____ EMAIL: _____

RIDING FOR THE DISABLED ASSOCIATION OF AUSTRALIA LIMITED ANNUAL PARTICIPANT REGISTRATION FORM



6. MEDICAL DETAILS

Do you have or have had any medical condition or disability (eg. Physical, intellectual, psychiatric or behavioural that may affect your efficiency as a participant, your safety and the safety of the public? Yes / No

If YES, you will be required to submit a Medical Consent Form completed by a medical practitioner with this application. A Medical Consent Form is available from State office. RDA may in its reasonable discretion require you to provide a Medical Consent Form completed by a medical practitioner even if you have declared you do not have / had any medical condition or disability.

7. RENEWING PARTICIPANT MEDICAL INFORMATION

Have any medical conditions changed in the last 12 months? Yes / No

If YES please have your medical practitioner complete a review of the Medical Consent Form.

Has the client undergone any Medical Procedures (surgery etc) in the last 12 months? Yes / No

If YES please have your medical practitioner complete a review of the Medical Consent Form.

8. DISABILITY CATEGORY (Tick one box only)

- | | | | |
|---|--------------------------|---|--------------------------|
| A. Rider with intellectual disability | <input type="checkbox"/> | G. Rider with Learning/Behavioural Difficulty | <input type="checkbox"/> |
| B. Rider with Physical disability | <input type="checkbox"/> | H. Riders with Psychiatric Condition | <input type="checkbox"/> |
| C. Rider with Cerebral Palsy | <input type="checkbox"/> | I. Rider with Multiple Disability | <input type="checkbox"/> |
| D. Rider with Vision Impairment/Blindness | <input type="checkbox"/> | J. Rider with Down Syndrome | <input type="checkbox"/> |
| E. Rider with Hearing Impairment/Deafness | <input type="checkbox"/> | K. Rider without disability | <input type="checkbox"/> |
| F. Rider with Autism | <input type="checkbox"/> | L. Other Disability | <input type="checkbox"/> |

What is the client's Medical Condition/s:

9. DECLARATION

I have read, understood, acknowledge and agree to the declarations in this application and will abide by the policies and procedures of my RDA Centre, State Association and RDA Australia Ltd. I warrant that all information provided is true and correct. I acknowledge that a copy of this Application has the same legal effect as the original.

SIGNATURE: _____ DATE: _____

10. PARENT/LEGAL GUARDIAN CONSENT (IN RESPECT TO AN APPLICANT UNDER THE AGE OF 18 YEARS OR WHERE INFORMED CONSENT CANNOT BE PROVIDED).

I have read, understood, acknowledge and agree to the declarations in this application and conditions of membership under the policies and procedures of my RDA Centre, State Association and RDA Australia Ltd. I warrant that all the information provided is true and correct.

SIGNATURE: _____ NAME: _____ DATE: _____

Personal information is collected for the purpose of billing and contact details, statistical and data collection for marketing and reporting to government agencies. This may include the Australian Sports Commission and its State bodies, Department of Disability and NDIS and Departments for Health and Community Care.