

METHOD APPLICATION FORM 2018



METHOD
ACTORS' TRAINING CENTRE
AKTEURS-OPLEIDINGSENTRUM

A – PERSONAL DETAILS			
SURNAME			
FIRST NAME/S			
ID NUMBER			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RESIDENTIAL ADDRESS		POSTAL ADDRESS	
		CODE	
		E-MAIL ADDRESS:	
TELEPHONE	HOME:	CELL:	
	WORK:		
HOME LANGUAGE	<input type="checkbox"/> ENGLISH	<input type="checkbox"/> AFRIKAANS	OTHER:
CONTACT NAME: (PARENT / SPOUSE/ FRIEND / ROOMMATE)			
CONTACT RESIDENTIAL ADDRESS		CONTACT POSTAL ADDRESS	
		CODE	
CONTACT TELEPHONE	HOME:	CELL:	
	WORK:		
B – QUALIFICATIONS			
HIGHEST QUALIFICATION ATTAINED:			
SPECIAL SKILLS / INTERESTS e.g. Music, Photography:			
C – COMMITMENTS			
May your responsibilities re: career / studies / relationships interfere with frequent class / workshop attendance and / or participation in the year-end show? If "yes" explain on reverse side:			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
Are your parents and / or spouse / partner supportive regarding your commitment to this course? If "no" explain on reverse side:			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
D – HEALTH			
HEALTH PROBLEMS WE SHOULD KNOW ABOUT? EXPLAIN ON REVERSE SIDE PLEASE.			
EPILEPSY / HAEMOPHILIA		DIABETES / CANCER	
CHRONIC KIDNEY / URINARY PROBLEMS		ASTHMA / BRONCHITIS	
ALLERGIES		ALCOHOL / DRUG DEPENDENCE / ABUSE	
NECK / BACK PROBLEMS		PSYCHIATRIC / BEHAVIOUR PROBLEMS	
HIV / AIDS		OTHER (SPECIFY)	
ARE YOU AWARE OF ANY PHYSICAL HANDICAPS OR INJURIES THAT COULD LIMIT YOUR PARTICIPATION IN PHYSICALLY ACTIVE CLASSES?			<input type="checkbox"/> YES <input type="checkbox"/> NO

It will be to your detriment to hide alcohol / drug dependence or conditions like bipolar or attention deficit disorder, depression or ANY dependence / psychiatric / psychological or behaviour problems.

I hereby declare the above information correct:

Signed at (City) _____ on the _____ day of _____, 20 _____

Applicant

Parent/Guardian if applicant is under 18