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**CHIP Program Registration**

**SCHEDULED CHIP PROGRAM COMMENCMENT DATE**

**Name of Hosting Organisation**

**ABN or Business Licence number** (for businesses only)

**Billing Address**

**City**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State/ Territory \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode

**Phone: Office / Mobile ( )**

**E-mail:**

**Type of Program** □ Online **Resources Required** □ CHIP Kits

**□** In person  □ CHIP Hub

□ Hybrid (online and in-person) □ CHIP Drive (USB)

**Program Length: □** Short (20-28 mins long) □ Long (20-45 mins long)

**Minimum group size:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Maximum group size:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your program limited to a certain demographic** (e.g. retirees, young mums, unemployed, people with high blood sugar etc.)?

□ No □ Yes (provide details) :

**CHIP Program Venue:**

**City:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State/Territory:**\_\_\_\_\_\_\_\_ **Post Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lead Facilitator Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone:** Home/Mobile ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Certified CHIP Facilitators Assisting in Program :** (Name and Email Address- attach separate document if needed)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hosting Organisation CEO or Board Chairman contact details:**

**Name**

**Position** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate your anticipated charges for the program.**

**Level 1** (Includes Attendance, CHIP Kit/ CHIP Hub, Bloods, Program Expenses) **$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Level 2** (Includes Attendance, Bloods, Program Expenses) **$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Level 3** (Includes Attendance, Program Expenses) **$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Level 4** (Includes FREE Spouse Attendance Bloods, Program Expenses) **$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Level 5** (Includes FREE Attendance only ) **$\_\_\_\_\_\_0\_\_\_\_\_\_\_\_**

***Contact LMI for a current price list of CHIP resources*.**

**Please email the following to support this registration :**

1. List of scheduled program dates (Template attached)
2. Copy of insurance cover.

**Return Completed Form to LMI CHIP 3 weeks prior to program commencing:** [ask@chiphealth.com.au](mailto:ask@chiphealth.com.au)

Phone +61 98473 367 if you have any questions.

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| --- | --- | --- | --- | --- |
| **COMPLETE HEALTH IMPROVEMENT PROGRAM SCHEDULE** | | | | |
| **Session Number** | **Month** | **Date** | **Day** | **Time** |
| Information Session |  |  |  |  |
| Orientation Session |  |  |  |  |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
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| 15 |  |  |  |  |
| 16 |  |  |  |  |
| 17 |  |  |  |  |
| 18 |  |  |  |  |
| **Celebration Ceremony: Date / Type / Time / Venue** | | | | |
| **NOTES:** | | | | |