**Inpatient Tobacco Dependence Adviser Training Course:**

**Acute Inpatient**

**Registration Form**

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| **Participant details** | |
| 1. Name |  |
| 2. Hospital trust |  |
| 3. What is your job title? |  |
| 4. What is your NHS band? |  |
| 5. What is your professional background? | Social worker  Nurse  Pharmacist  Physician  Other (specify): |
| 6. Work address |  |
| 7. Email address |  |
| 8. Telephone number |  |
| 9a. Do you have any training   accessibility requirements? | Yes  No |
| 9b. If yes, let us know what   these requirements are |  |
| 10. How long have you worked   in tobacco dependency? | New to this work  Less than 1 year  1 to 5 years  6 to 10 years  More than 10 years |

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| 11. How long have you worked   in the inpatient acute setting? | New to this setting  Less than 1 year  1 to 5 years  6 to 10 years  More than 10 years |
| 12. What are the **three** main things   you hope to gain from attending   the course? |  |
| 13. Any other comments: |  |

**Thank you for registering for this two day Inpatient Tobacco Dependence Adviser Training course. You will receive a confirmation email with details on course within two working days.**

**For additional information please contact:**

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