

IA Support Volunteers Effective Communication Skills

Please ensure that you read the accompanying course information before completing this form. **Please use BLACK ink.**

All information provided will be held securely and used only for the purposes of facilitating the individuals' participation in IA's One2One Support. The individuals reserve the right to withdraw their consent for the retention of their personal data at any time and can do so by contacting national office. To see a copy of IA's privacy notice, please visit www.iasupport.org, or contact national office via info@iasupport.org / tel. 0800 0184 724 to request a hard copy."

Full Name:	Mr / Mrs / Ms / Other (please state)						
Address:							
Postcode:		Phone:	Mobile:				
Email:							
-		Please tick as appropriate					
Date of birth		Ileostomy 🗆	Internal Pouch	Other \square			
Name of IA M	ember Organisation						
Date of opera	tion:	Occupation:					
What involvement do you have with your local IA member organisation?							
	vant to be an IA						
Support Volur	nteer?						
What do you l	nope to gain from this						

What do you think you could bring to this course?							
Are you alreasupport volu	ady being used as a nteer? for your local member for your local clinical n		No				
Any addition	al information to suppor	t your application?					
	below to confirm that all nd understood the accor		have given on this form is accurate and primation.	l that you			
Signature of	applicant:						
Date:							
If you are unal	supported by: ble to complete this section e submitting your application	n, please email <u>(info@ias</u> on)	support.org or anne.demick@iasupport.org	to			
Official from	your local IA member o	rganisation or a clinic	cal nurse specialist in stoma care				
Signed:							
Name in bloo	ck capitals:						
Office held:							
Date:							

Please return this form to:

IA National Office, Danehurst Court, 35-37 West Street, Rochford, Essex SS4 1BE or email to info@iasupport.org