WORKSHOPS FOR SIBLINGS OF PERSONS WITH DISABILITY

Name and Surname of participant: _____

ID Card number: _____

Email Address: _____

Contact number: _____

Age of sibling: _____

Relationship with person with disability: _____

Gender of the person with disability: _____

Disability information / Diagnosis: _____

Language Preference: Maltese ____ English ____

Time preference: Morning ____ Evening ____

What may hinder you from attending:

_____

_____

List any topics that are of interest to you:

_____

_____

_____

_____

What are you expecting from these workshops?

Information ____

Help and assistance ____

Talks from professionals ____

Applications are to be sent by post to:

Adult Siblings Workshops

Family Support Unit, Aġenzija Sapport

Patri Ġwann Azzopardi Street, Santa Venera SVR 1614

OR by email on workshops.sapport@gov.mt