

**Diabetes Conversation Maps Tool Training Workshop**

**12 & 19 September, 2015**

**Objectives:** The workshop is designated to equip the primary health care nurses with the relevant knowledge on diabetes, so that they would be able to understand the Diabetes Conversation Maps Tools (DCMT) to provide education to people with diabetes, and to empower them on behavior change & better self-management.

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| **Date** |  **:** | 12 & 19 September, 2015 (Sat) |
| **Time** | **:**  | 2:00pm – 5:30pm |
| **Training Team :****:** | Ms. HUNG Shuk -yee & Ms. Tina NG |
| **Venue** | **:** | Eaton Hotel, Jordan |
| **Remark** | **:** | Refreshment & Afternoon tea will be provided |
| **Target** **Participants :** | Priority for members of Hong Kong Association of Family & Primary Health Care Nurses |

Upon completion of the training, participants will be i) accredited with **3 CNE points** for each class, ii) allowed to use the Map Tools to conduct patient sessions; iii) awarded a facilitator certificate provided that they *have successfully conducted at least* ***ONE*** *DCMT patient session with at least three participants of the class within nine months after training, AND submit the session evaluation form*.

For registration, please complete the reply slip and fax to **2572 7893** on or before **4th September (Fri).** Registration will be considered on first come first serve basis. Successful applicants will be notified individual on or before **11th September (Fri)** for confirmation of course acceptance. Please contact Ms Tina Ng at 9030 8709 if you have any enquiry

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**♠ Reply Slip ♠**

Please fax the reply slip to **2572 7893** *(Attn: Ms. Tina NG)*

**Registration Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prefix (circle one): Ms. / Miss / Mr.

Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post / Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital / Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery Address\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have diabetes care / education experience □ No □ Yes, with \_\_\_\_ year(s)

*\*Please provide your office address for receiving the pre-works materials before the workshop*

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