

**Application Form for Participation Partner**

*Details entered in this part of the form will be held in by the Patient Voice and Involvement team for up to three years. By completing and returning this form, you are agreeing to have your details stored for this period of time. You are welcome to contact the team and terminate your application/information at any time.*

Personal details

|  |  |
| --- | --- |
| Surname/Family Name |  |
| First Name |  |
| Title |  |
| Address |  |
| Postcode |  |
| Home telephone |  |
| Mobile Telephone |  |
| Email Address |  |
| Please let us know what your areas of interest are. | |
|  | |
| Is there anything else you would like us to know? | |
|  | |

|  |
| --- |
| East Kent Hospitals is an NHS Foundation Trust. Members of the public can apply to be a member. Membership is free. Would you like to become a trust member? |
| YES NO |
| Please state your usual availability. |
| * Thursday PM * Friday AM * Friday PM * Saturday * Sunday * Other (please specify) * Monday AM * Monday PM * Tuesday AM * Tuesday PM * Wednesday AM * Wednesday PM * Thursday AM |

**Communication and access needs**

|  |
| --- |
| Please tell us if you have any communication or access needs, so that we can enable you to participate. This could include information in large print, wheelchair access for meetings, a hearing loop or any other adjustment: |
|  |

**References – Please provide two references from people who have known you for at least three years**

**Referee 1**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname/Family name |  | Title |  |
| First name |  | | |
| Address |  | | |
| Post Code |  | | |
| Telephone |  | | |
| Email |  | | |
| Relationship/Profession  (how does this person know you) |  | | |

**Referee 2**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname/Family name |  | Title |  |
| First name |  | | |
| Address |  | | |
| Post Code |  | | |
| Telephone |  | | |
| Email |  | | |
| Relationship/Profession  (how does this person know you) |  | | |

**DECLARATION**

I confirm that the information on this form is true and complete:

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | | |
| Name |  | Date |  |

**EQUALITY MONITORING INFORMATION**

The information collected will only be used for monitoring purposes in an anonymised format and will help the Trust analyse the profile and make up our volunteers to support our equal opportunities policy.

We recognise and actively promote the benefits of a diverse range of volunteers and are committed to treating all volunteers with dignity and respect regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and sexual orientation.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \* Date of Birth |  | | Age |  |
| \* Gender | 🞎 Male  🞎 Female  🞎 Non-binary  🞎 I do not wish to disclose this | | | |
| Is your gender identity the same as the sex you were assigned at birth? Yes 🞎 No 🞎 | | | | |
| I do not wish to disclose 🞎 | | | | |
| **\* I would describe my ethnic origin as:** | | | | |
| **Asian or Asian British**  🞎 Bangladeshi  🞎 Indian  🞎 Pakistani  🞎 Chinese  🞎 Any other Asian background  **Black or Black British, Caribbean or African**  🞎 African  🞎 Caribbean  🞎 Any other Black, Black British or Caribbean background | | **Mixed or Multiple Ethnic Groups**  🞎 White & Asian  🞎 White & Black African  🞎 White & Black Caribbean  🞎 Any other mixed or multiple ethnic background  **Other Ethnic Group**  🞎 Arab  🞎 Any other ethnic group  **White**  🞎 English, Welsh, Scottish, Northern Irish or British  🞎 Irish  🞎 Gypsy or Irish Traveller  🞎 Roma  🞎 Any other White background  🞎 I do not wish to disclose this information | | |
| \* Do you consider yourself to have a disability or long-term health condition? | | 🞎 Yes (please complete the section below)  🞎 No  🞎 I do not wish to disclose this information | | |
| Please state the type of disability / impairment which applies to you. People may experience more than one type of impairment, in which case you may indicate more than one. If none of the categories apply, please mark ‘other’. | | | | |
| 🞎 Physical Impairment 🞎 Learning Disability/Difficulty  🞎 Sensory Impairment (hearing / sight) 🞎 Long-Term Health Condition  🞎 Neurodiversity (Autism, AH, ADHD, Dyslexia, Dyspraxia)  🞎 Other  🞎 Lived experience of mental health | | | | |

**Sexual Orientation**

Please select which sexual orientation applies to you:

|  |  |
| --- | --- |
| Heterosexual or straight |  |
| Gay or lesbian |  |
| Bisexual |  |
| Other sexual orientation not listed (please state) |  |
| I do not wish to disclose |  |

**Please return the completed forms to:**

**Email:** [ekhuft.patientvoice@nhs.net](mailto:ekhuft.patientvoice@nhs.net)

**Write to us:** The Patient Voice and Involvement Office, Trust Offices, Kent and Canterbury Hospital, Canterbury, Kent, CT1 3NG