

EQUAL OPPORTUNITIES FORM

Full Name: _____

Date of Birth (DD/MM/YYYY) _____

1 Ethnicity Monitoring

Please tick a box below to identify your ethnicity. We use this data to help us evaluate our services and plan for future provision:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Black or Black British Caribbean | <input type="checkbox"/> Asian or Asian British Indian | <input type="checkbox"/> Mixed - White and Black Caribbean |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Black or Black British African | <input type="checkbox"/> Asian or Asian British Pakistani | <input type="checkbox"/> Mixed - White and Black African |
| <input type="checkbox"/> Arab | <input type="checkbox"/> Other Black background | <input type="checkbox"/> Asian or Asian British Bangladeshi | <input type="checkbox"/> Mixed - White and Asian |
| <input type="checkbox"/> Information refused | <input type="checkbox"/> Other Ethnic Background | <input type="checkbox"/> Other Asian Background | <input type="checkbox"/> Other Mixed background |

2 Disability Monitoring

If you have any special requirements due to a disability or long-term medical condition please let us know full details **on the application form** so we can try to offer facilities which meet your needs. If you prefer to discuss this in confidence you can contact the Head of Saturday Centre on 07931 387101. Data on this page will be used to help us evaluate our services and plan for future provision and also to prompt us to contact you with advice and support if you are offered a position

a) Do you have a disability or long-term medical condition? If so, please specify which using the tick boxes below: Yes No

- | | | |
|--|---|---|
| <input type="checkbox"/> A social/communication impairment such as Asperger's syndrome or other autistic spectrum disorder | <input type="checkbox"/> Deafness or serious hearing impairment | <input type="checkbox"/> Blind or have a serious visual impairment uncorrected by glasses |
| <input type="checkbox"/> A long-standing illness or health condition such as cancer, HIV, diabetes, chronic heart disease, or epilepsy | <input type="checkbox"/> Specific learning difficulty such as dyslexia, dyspraxia or AD(H)D | <input type="checkbox"/> A mental health condition, such as depression, schizophrenia or anxiety disorder |
| <input type="checkbox"/> Physical impairment or mobility issues, such as difficulty using your arms or using a wheelchair or crutches | <input type="checkbox"/> Two or more impairments and/or disabling medical conditions | |
| <input type="checkbox"/> A disability, impairment or medical condition that is not listed above (I) | | |

Signature _____

Date _____