



Role applied for: Health systems panel for CLAHRC West

All questions which you are required to complete are marked with an asterisk (*).

1. Personal details

Title (e.g. Mr / Mrs / Ms / Dr)	
*Surname/Family Name	
*First Name	
*Address	
*Postcode	
Home Telephone	
Work Telephone	
Mobile Telephone	
*Preferred daytime telephone number	<input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work
*Email Address	

2. Background/perspective

*Which of the following best describes the primary perspective you would bring to this role? (Please put an X in one box only and use the space below to tell us about other key perspectives)
<input type="checkbox"/> Service user / patient <input type="checkbox"/> User researcher (including survivor researchers) <input type="checkbox"/> Carer (including family member, parent, supporter) <input type="checkbox"/> Other, please give details:
Any other comments on the perspective you would bring:

3. Links

If you are currently working or active in a voluntary capacity, please give details. (If you have more than one main role, please add rows or continue on a separate sheet if necessary.)			
Role title/position	Name of organisation	Dates	Brief description of your role and responsibilities

*Please give details of any previous experience of public involvement and of links to any involvement related groups, committees, networks or other organisations. (Please add more rows or continue on a separate sheet if necessary.)	
Name of the group/committee	Your involvement experience and/or role in the group/committee

4. Skills and experience

Please tell us why you are interested and how your life and work experience will help you with reference to the role profile (no more than 200 words)

5. Availability

Please give an indication of your availability.

6. Your support requirements

If you have any support requirements to ensure you can take full part in this role, please tell us about them here.

7. Your declaration

I agree to this information only being used for legitimate purposes connected with my involvement as a public contributor with People in Health West of England and NIHR CLAHRC West.

I declare that the information that I have given is, to the best of my knowledge or belief, true and complete.

I understand and agree to abide by People in Health West of England's involvement expectations and confidentiality document.

I agree to the above declaration			
Signature			
Name		Date	

How did you hear about this opportunity e.g. People in Research West of England website, from a colleague, other sources? (Please give details)

Please return this form (including equality monitoring form below) by Thursday 16th February 2017 to:

Rosie Davies, Research Fellow (Patient and Public Involvement), NIHR CLAHRC West by email or post. Email: Rosemary3.Davies@uwe.ac.uk.

Postal address: NIHR CLAHRC West, University Hospitals Bristol NHS Foundation Trust, 9th Floor, Whitefriars, Lewins Mead, Bristol BS1 2NT

If you need any more information or if you have any questions about your application please get in touch with Rosie Davies.

Equality Monitoring Form

To help us monitor the diversity of the people we are reaching, please help us by filling in the following questions. The information you provide is confidential and will be used for monitoring purposes only.

Please indicate your age	<input type="checkbox"/> 15 and under <input type="checkbox"/> 16-24 <input type="checkbox"/> 25-44	<input type="checkbox"/> 45-64 <input type="checkbox"/> 65-74 <input type="checkbox"/> 75 and over
Please indicate your gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> I do not wish to disclose this
What is your preferred language?		

* Please indicate your ethnic origin		
Asian or Asian British <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Any other Asian background Black or Black British <input type="checkbox"/> African <input type="checkbox"/> Caribbean <input type="checkbox"/> Any other Black background	Mixed <input type="checkbox"/> White & Asian <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> Any other mixed background White <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other White background	Other Ethnic Group <input type="checkbox"/> Chinese <input type="checkbox"/> Any other ethnic group <input type="checkbox"/> I do not wish to disclose this

Please indicate your religion or belief		
<input type="checkbox"/> Atheism <input type="checkbox"/> Buddhism <input type="checkbox"/> Christianity <input type="checkbox"/> Hinduism	<input type="checkbox"/> Islam <input type="checkbox"/> Jainism <input type="checkbox"/> Judaism <input type="checkbox"/> Sikhism	<input type="checkbox"/> Other <input type="checkbox"/> I do not wish to disclose this

Do you consider yourself to have a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not wish to disclose this information
Please state the type of 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'.	
<input type="checkbox"/> Physical impairment <input type="checkbox"/> Sensory impairment <input type="checkbox"/> Mental health condition	<input type="checkbox"/> Learning Disability/Difficulty <input type="checkbox"/> Long-standing illness <input type="checkbox"/> Other

Please indicate the option which best describes your sexual orientation	
<input type="checkbox"/> Lesbian <input type="checkbox"/> Gay <input type="checkbox"/> Bisexual	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Other <input type="checkbox"/> I do not wish to disclose this