

PUBLIC CONTRIBUTOR

## APPLICATION FORM

Contact Emily Dodd for word version please

emily3.dodd@uwe.ac.uk



People in Health  
West of England

Better involvement · Better research · Better health

### Role applied for: Stroke Health Integration Team (HIT) Peer Director

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 <b>one box only</b> and use the space on the next page 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. Skills and experience

\* Please give details here of any previous employment experience or voluntary role you have undertaken that you would like to tell us about

Role title/position	Name of organisation	Dates	Brief description of your role and responsibilities

### 4. Links to patient and public involvement (PPI) organisations

\*Please give details of your links to any PPI related groups, committees, networks or other organisations (Please add more rows or continue on a separate sheet as necessary)

Name of the group/committee	Your role in the group/committee

### 5. Why you are interested in this role

\* Please tell us what your interest in the role is and how your experience will contribute to the work of the organisation, with particular reference to the role profile. Include here (no more than 200 words)

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## 6. Rehabilitation of Offenders Act 1974

\* Have you ever been convicted of a criminal offence?

Yes

No

*(Declaration subject to the Rehabilitation of Offenders Act 1974)*

## 7. Availability

Please give us here some indication of your availability.

## 8. 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.



## 9. References

Please give us the names and contact details of two people who can support your application to be a public contributor.

### Referee 1

Title			
*Surname/Family name		* First Name	
*Relationship to you			
*Address			
*Postcode			
Telephone			
Email			

### Referee 2

Title			
*Surname/Family name		* First Name	
*Relationship to you			
*Address			
*Postcode			
Telephone			
Email			



## 10. Your declaration

I agree to this information only being used for legitimate purposes connected with your involvement as a public contributor.

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 the confidentiality policy of our partner organisations.

I agree to declare any conflicts of interests<sup>1</sup>.

I agree to the above declaration			
Signature			
Name		Date	

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

**Please return this form either via email or post (including equality monitoring form below) to:**

Emily Dodd, Stroke Health Integration Team Co-ordinator : [Emily3.Dodd@uwe.ac.uk](mailto:Emily3.Dodd@uwe.ac.uk)

Room 3L07, Frenchay Campus

University of the West of England

Coldharbour Lane

Bristol BS16 1QY

**If you need any more information or if you have any questions about your application please get in touch with Emily or your project contact.**

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<sup>1</sup> Directorships held in private companies, ownership in private companies etc.



## 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		
<b>Asian or Asian British</b> <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Any other Asian background <b>Black or Black British</b> <input type="checkbox"/> African <input type="checkbox"/> Caribbean <input type="checkbox"/> Any other Black background	<b>Mixed</b> <input type="checkbox"/> White & Asian <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> Any other mixed background <b>White</b> <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other White background	<b>Other Ethnic Group</b> <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
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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



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