

**Application Form**

**Please return completed forms to;**

Karl Mayes, PPI & Membership Manager, Medical Illustration Department. Level 2, Windsor Building, Leicester Royal Infirmary. Infirmary Square, Leicester LE1 5WW

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**Name:**

**Address:**

**Telephone:**

**Email:**

**D.O.B.:**

**Do you consider yourself to be disabled?**

**How would you describe your ethnicity?**

**Gender:**

**Please tell us about your experience as a patient or carer.**

**Please tell us your motivation for becoming a Patient Partner and why you feel you would make a good Patient Partner**

(Please refer to the Patient Partner role outline and in particular the core skills required for the role).

 **Please provide a brief summary of your work experience**

**Please tell us what support you would require to carry out the Patient Partner role if applicable.**

**Name of Referee 1:**

**Address:**

**Please provide contact details for two referees**

(Referees must have known you for a minimum of three years)

**Telephone:**

**Email:**

**Relationship to you:**

**Name of Referee 2:**

**Address:**

**Telephone:**

**Email:**

**Relationship to you:**

**I confirm that the information I have provided in this form is accurate and that I wish to be considered for the role of Patient Partner.**

**Signed: Date:**