



**Patient Partners**

# Application Form

**Please return completed forms to;**

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**Name:**

**Address:**

**Telephone:**

**Email:**

**D.O.B.:**

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

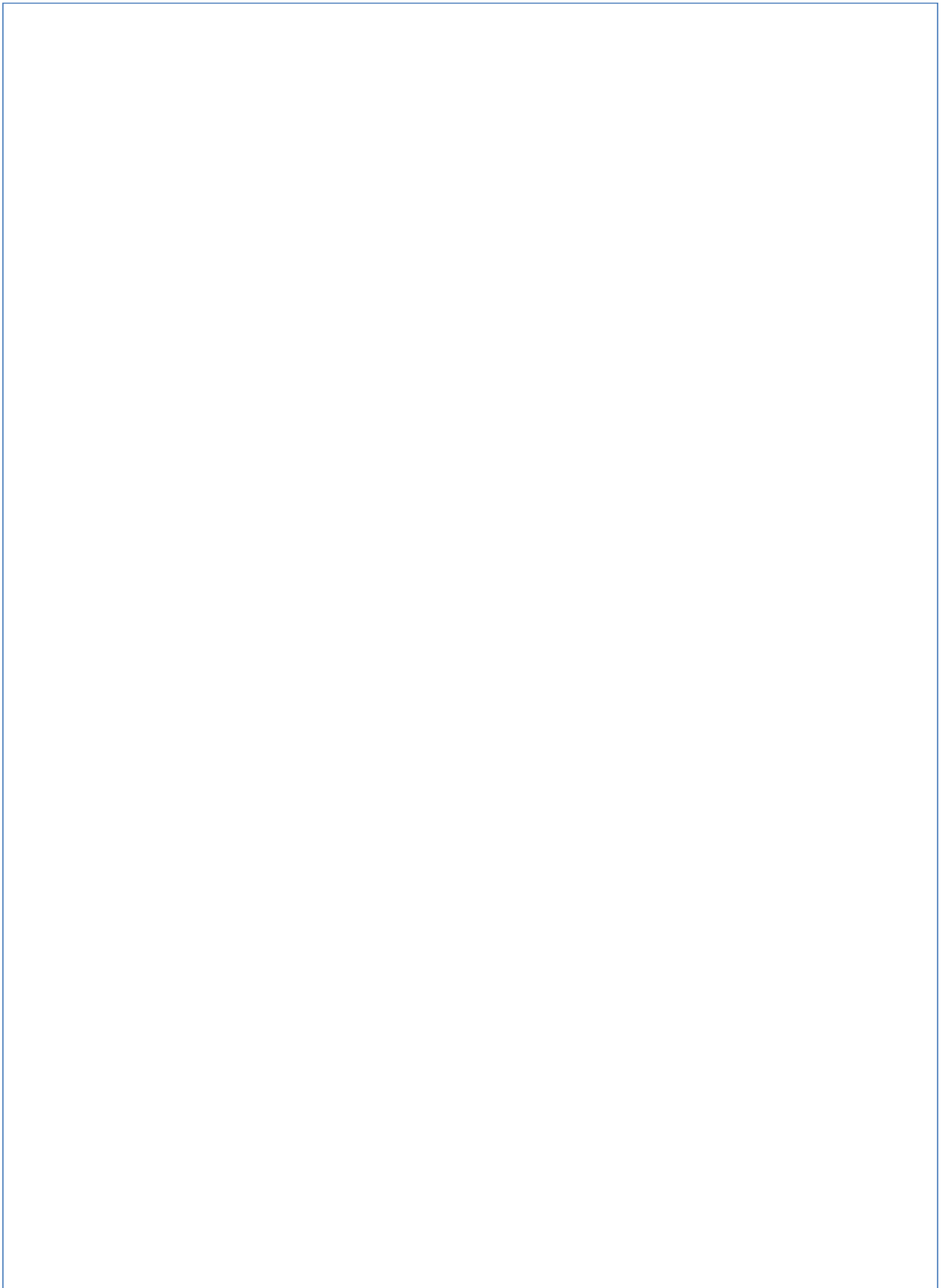
**How would you describe your ethnicity?**

**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.**

## Please provide contact details for two referees

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

<b>Name of Referee 1:</b>
<b>Address:</b>
<b>Telephone:</b>
<b>Email:</b>
<b>Relationship to you:</b>

<b>Name of Referee 2:</b>
<b>Address:</b>
<b>Telephone:</b>
<b>Email:</b>
<b>Relationship to you:</b>

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:**