Application Form

Patient Partners

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
Karl.mayes@uhl-tr.nhs.uk

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)

Name of Referee 1:
Address:
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:**