

# Reading Panel Registration Form



## 1. Contact Details

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Telephone: \_\_\_\_\_

Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Tenant  Leaseholder

Gender: MALE  FEMALE

## 2. Ethnicity

Please indicate which of the following groups you belong to:

White: British	<input type="checkbox"/>	Black or Black British: Caribbean	<input type="checkbox"/>
White: Irish	<input type="checkbox"/>	Black or Black British: African	<input type="checkbox"/>
White: Other	<input type="checkbox"/>	Black or Black British: Other Black	<input type="checkbox"/>

Asian or Asian British: Indian	<input type="checkbox"/>	Mixed: White & Black Caribbean	<input type="checkbox"/>
Asian or Asian British: Pakistani	<input type="checkbox"/>	Mixed: White & Black African	<input type="checkbox"/>
Asian or Asian British: Bangladeshi	<input type="checkbox"/>	Mixed: White & Asian	<input type="checkbox"/>
Asian or Asian British: Other Asian	<input type="checkbox"/>	Mixed: Other Mixed	<input type="checkbox"/>

Chinese or Other Ethnic Group: Chinese

Chinese or Other Ethnic Group: Other Group

**Please Turn Over**

### 3. Disability

Do you consider yourself as having a long term disability? YES  NO

If you have answered 'YES' please indicate the nature of your disability:

Dyslexia	<input type="checkbox"/>	Learning disability	<input type="checkbox"/>
Mobility (physical disability)	<input type="checkbox"/>	Multiple disability	<input type="checkbox"/>
Mental health difficulty	<input type="checkbox"/>	Other (Please State)	<input type="checkbox"/>
Blind / Partially Sighted	<input type="checkbox"/>	_____	
Progressive disability	<input type="checkbox"/>	_____	
Deaf / Hearing loss	<input type="checkbox"/>		

If you have a disability do you currently get any of the following?

Disability Living Allowance	<input type="checkbox"/>
Attendance Allowance	<input type="checkbox"/>
Incapacity Benefit / Income Support	<input type="checkbox"/>
Care or Support from Social Services	<input type="checkbox"/>

### 4. Caring Responsibility

Do you provide care for a relative or friend who has a long term illness or disability?

YES  NO

If you have answered 'YES', how much time do you spend on your caring responsibility?

1 to 5 hours per week	<input type="checkbox"/>
6 to 10 hours per week	<input type="checkbox"/>
11 to 15 hours per week	<input type="checkbox"/>
16 or more hours per week	<input type="checkbox"/>

### 5. Religion

Please indicate which of the following faith groups you belong to:

Christian	<input type="checkbox"/>	Muslim	<input type="checkbox"/>
Buddhist	<input type="checkbox"/>	Sikh	<input type="checkbox"/>
Hindu	<input type="checkbox"/>	Other Religion	<input type="checkbox"/>
Jewish	<input type="checkbox"/>	No Religion	<input type="checkbox"/>

### 6. Sexuality

Please indicate if you are:

Heterosexual	<input type="checkbox"/>	Bisexual	<input type="checkbox"/>
Lesbian	<input type="checkbox"/>	Gay Man	<input type="checkbox"/>

### 7. Language

Do you require information in another language?

NO  YES  \_\_\_\_\_