# Customer Involvement Registration Form

Which activity/ies would you like to be involved with? ______________________________

## 1. Contact Details

Name: ______________________________

Address: ______________________________

______________________________

Postcode: ______________ Tenant ☐ Leaseholder ☐

Date of Birth: ______________

Telephone: ______________ Gender: MALE ☐ FEMALE ☐

Mobile: ______________ TRANSGENDER ☐

Email: ______________________________

## 2. Ethnicity

Please indicate which of the following groups you belong to:

White: British ☐

White: Irish ☐

White: Other ☐

______________________________

Black or Black British: Caribbean ☐

Black or Black British: African ☐

Black or Black British: Other Black ☐

______________________________

Asian or Asian British: Indian ☐

Asian or Asian British: Pakistani ☐

Asian or Asian British: Bangladeshi ☐

Asian or Asian British: Other Asian ☐

______________________________

Mixed: White & Black Caribbean ☐

Mixed: White & Black African ☐

Mixed: White & Asian ☐

Mixed: Other Mixed ☐

______________________________

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 | ☐ | Learning disability | ☐ |
| Mobility (physical disability) | ☐ | Multiple disability | ☐ |
| Mental health difficulty | ☐ | Other (Please State) | ☐ |
| Blind / Partially Sighted | ☐ | ______________________ | |
| Progressive disability | ☐ | ______________________ | |
| Deaf / Hearing loss | ☐ | | |

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

| | | | |
|---|---|---|---|
| Disability Living Allowance | ☐ | Incapacity Benefit / Income Support | ☐ |
| Attendance Allowance | ☐ | Care or Support from Social Services | ☐ |

## 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 | ☐ | 11 to 15 hours per week | ☐ |
| 6 to 10 hours per week | ☐ | 16 or more hours per week | ☐ |

Do you claim for any caring benefits?
NO ☐ YES ☐ (please sate) ______________________

## 5. Religion

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

| | | | |
|---|---|---|---|
| Christian | ☐ | Muslim | ☐ |
| Buddhist | ☐ | Sikh | ☐ |
| Hindu | ☐ | Other Religion | ☐ ______________________ |
| Jewish | ☐ | No Religion | ☐ |

## 6. Sexuality

Please indicate if you are:

| | | | |
|---|---|---|---|
| Heterosexual | ☐ | Bisexual | ☐ |
| Lesbian | ☐ | Gay Man | ☐ |

## 7. Communication Needs

Do you require information in another language?
NO ☐ YES ☐ ______________________

What is your preferred method and time to contact you?

______________________