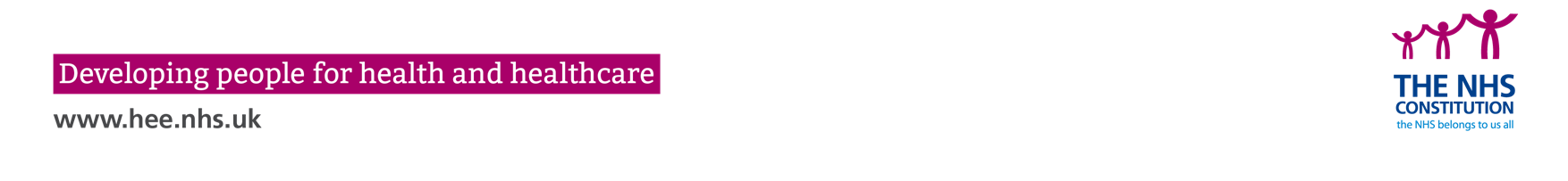




**Health Education England**

**Clinical Scholar Awards**

**Mentor Registration Form**



Notes for Guidance

* This opportunity is sponsored and managed by Health Education England (HEE).
* This form should be used if you wish to register as a Mentor for the HEE Clinical Scholar Awards.
* Before completing this form, please refer to the guidance notes and Frequently Asked Questions (FAQs) at <http://www.nottingham.ac.uk/clinicalscholar>
* Deadline for submission 1.9.16
* Please complete the form in BLOCK CAPITALS or type, so that your information can be easily read.
* When completing the form please ensure that you provide your full name (surname/family name and forenames) in the order they appear in your official documents i.e. passport.
* If your supporting documents are not in English, we require officially translated versions as well as copies in the original language.
* Please send your completed forms to **Patricia Dziunka by e-mail (**[**patricia.dziunka@nottingham.ac.uk**](mailto:patricia.dziunka@nottingham.ac.uk)**) or send to: Patricia Dziunka**

**B114, Division of Rehabilitation & Ageing**

**University of Nottingham**

**Medical School, QMC**

**Nottingham NG7 2UH**

* Following submission and review of the registration form you will be notified as to the next stage of the mentoring process

If you have any questions about filling out your application form, please do not hesitate to contact **Kate Radford**

**Tel: 0115 8230226**

[**Email: kate.radford@nottingham.ac.uk**](mailto:Email:%20kate.radford@nottingham.ac.uk)

Data Protection Statement

By signing this form you are consenting to Health Education England (HEE) using the information provided from time to time, along with any further information about you that HEE may hold, for the purposes of the HEE Clinical Scholar Awards.

The information that you provide on your application form will be used for the following purposes:

* To enable you to register as a Mentor for the HEE Clinical Scholar Awards and allow the management team to assist you through the mentoring process;
* To enable HEE to compile statistics, or to assist other organisations to do so. No statistical information will be published that would identify you personally;
* To enable HEE to initiate your mentorship record should you be offered a place on the programme.

**Mentor Registration Form**

This form should be completed and returned (along with supporting documentation as required) to HEEM. Please complete the form in **BLOCK CAPITALS** or type.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PERSONAL DETAILS** | | | | | | | | | | | |
| Surname/Family Name: | | | |  | | First/Given Name(s): | | |  | | |
| Previous Surname/Family Name (if applicable):Pilbeam | | | | | | | | Title (Prof, Dr, Mr, Mrs, Ms) | | |  |
| Date of Birth: | |  | | | Gender: | | Nationality: | | | | |
| Country of Birth: | | | England | | | Country of Permanent Residence: | | | |  | |
| **ADDRESSES** | | | | | | | | | | | |
| Address for Correspondence: | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Derbyshire | | | | | | | | | | | |
| Post Code: |  | | | | | | | | | | |
| Mobile: |  | | | | | | | | | | |
| Tel: |  | | | | | | | | | | |
| Fax: |  | | | | | | | | | | |
| Email: |  | | | | | | | | | | |

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| --- | --- |
| **PROFESSION** | |
| Nursing □ | |
| Midwifery □ | |
| Allied Health | |
| Health Visiting □ | |
| Pharmacy □ | |
| Wider Dental Team □ | |
| Operating Department Practitioner □ | |
| Clinical Psychology □ | |
| Healthcare Scientist □ | |
| Chiropractor □ | |
| Optometrist □ | |
| Osteopath □ | |
| Optician □ | |
| Non-Medical Public Health Specialty Trainee □ | |
| Other (Please state): |  |

**PROFESSIONAL REGISTRATION**

|  |
| --- |
| Please provide details of professional registration including PIN number and date of registration for renewal.] |

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| **EDUCATION AND QUALIFICATIONS** | | | |
| Give details of the three highest classifications, further or higher education, since leaving school. Please provide information on qualifications already obtained and examinations still to be taken with the most recent first. | | | |
| **Name of Institution/Address** | **Dates**  **(mm/yyyy) of attendance** | **Qualification/Award (include class** & **division or grade obtained if known)** | **Main Subjects** |
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**APPLICATION QUESTIONS**

**Please complete the following application questions:**

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| **Please describe your experience of working in Clinical Research.**    2. **Woel** |
| 1. **Please describe your experience in managing/ supervising clinical researchers** |

|  |
| --- |
| 1. **Please outline the skills that you would bring to this role.** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **APPLICANT’S NAME:** | | | | |
| **HEAD OF DEPARTMENT’S (or equivalent) NAME:** | | | | |
| **Head of Department’s (or equivalent) Correspondence Address** | | Tel: |  | |
|  | | Mobile: |  | |
|  | | Email: |  | |
| Post Code: |  | Fax: |  | |
| **Supporting Letter**  Please attach a supporting letter from your Head of Department (or equivalent) confirming their support for you to partake and commitment to release you from your current duties for the appropriate amount of time for the duration of the programme. **To be completed in own time and therefore will not impact on work. Manager aware of application.**  Ld;sd;’ | | | | |
| Signature of Head of Department (or equivalent): | | | | Date: |

|  |  |  |  |
| --- | --- | --- | --- |
| **EMPLOYMENT DETAILS/OTHER EXPERIENCE** | | | |
| Give details of any industrial, professional or research experience relevant to your application. Continue on a separate sheet if necessary. | | | |
| **Employer** | **Title and duties of post** | **Dates From** | **Dates To** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**OTHER INFORMATION**

Do you have any criminal convictions? Yes No

NB: You are required to state whether or not you have any criminal convictions, excluding motoring offences for which a fine and/or up to three penalty points were imposed. If you tick the ‘yes’ box, you may be required to provide details of any convictions.

**DECLARATION**

I confirm that the information given on this form is true, complete and accurate and no information requested or other material information has been omitted.

**SPECIAL NEEDS OR SUPPORT**

Please state any support required as a consequence of any disability or medical condition.

|  |  |
| --- | --- |
| Signed: | Date: |

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| **MONITORING INFORMATION** |
| NHS England and Health Education England are committed to a policy of equal opportunities. In order to monitor the effectiveness of this policy, applicants are asked to complete this monitoring form. These statistics are used solely for the purpose of monitoring and form no part of the selection procedure. The monitoring form will be separated from your application. |
| Please tick the box which you feel describes your ethic origin. |
| White – British |
| White – Irish □ |
| Other White Background □ |
| Black or Black British – Caribbean □ |
| Black or Black British – African □ |
| Other Black Background □ |
| Asian or Asian British – Indian □ |
| Asian or Asian British – Pakistani □ |
| Asian or Asian British – Bangladeshi □ |
| Chinese or Other Ethnic Background – Chinese □ |
| Other Asian Background □ |
| Mixed – White and Black Caribbean □ |
| Mixed – White and Black African □ |
| Mixed – White and Asian □ |
| Other Mixed Background □ |
| Other Ethnic Background □ |
| Not Known □ |
| Information Refused □ |

|  |
| --- |
| **TO BE COMPLETED BY** ALL **APPLICANTS DISABILITY/SPECIAL NEEDS** |
| Please tick the box next to the statement which is most appropriate to you. |
| You do not have a disability nor are aware of any additional support requirements in study □ |
| You have dyslexia |
| You are blind/partially sighted □ |
| You are deaf/have a hearing impairment □ |
| You are a wheelchair user or have mobile difficulties □ |
| You need personal care support □ |
| You have mental health difficulties □ |
| You have an unseen disability, e.g. diabetes, epilepsy, asthma □ |
| You have two or more of the above disabilities/special needs □ |
| You have a disability not listed above Please Specify: |