



Health Education England

Clinical Scholar Awards

**Mentor Registration Form
2016/2017**

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) 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

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.

PERSONAL DETAILS			
Surname/Family Name:		First/Given Name(s):	
Previous Surname/Family Name (if applicable):			Title (Prof, Dr, Mr, Mrs, Ms)
Date of Birth:		Gender:	Nationality:
Country of Birth:		Country of Permanent Residence:	
ADDRESSES			
Address for Correspondence:			
Post Code:			
Mobile:			
Tel:			
Fax:			
Email:			
PROFESSION			
Nursing <input type="checkbox"/>			
Midwifery <input type="checkbox"/>			
Allied Health <input type="checkbox"/>			
Health Visiting <input type="checkbox"/>			
Pharmacy <input type="checkbox"/>			
Wider Dental Team <input type="checkbox"/>			
Operating Department Practitioner <input type="checkbox"/>			
Clinical Psychology <input type="checkbox"/>			
Healthcare Scientist <input type="checkbox"/>			
Chiropractor <input type="checkbox"/>			
Optometrist <input type="checkbox"/>			
Osteopath <input type="checkbox"/>			
Optician <input type="checkbox"/>			
Non-Medical Public Health Specialty Trainee <input type="checkbox"/>			
Other (Please state):			
PROFESSIONAL REGISTRATION			

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

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
	From:		
	To:		
	From:		
	To:		
	From:		
	To:		

APPLICATION QUESTIONS

Please complete the following application questions:

1. Please describe your experience of working in Clinical Research.

2. Please describe your experience in managing/ supervising clinical researchers

3. 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.

Signature of Head of Department (or equivalent):	Date:
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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

SPECIAL NEEDS OR SUPPORT

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

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.

Signed:

Date:

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 ethnic origin.
White – British <input type="checkbox"/>
White – Irish <input type="checkbox"/>
Other White Background <input type="checkbox"/>
Black or Black British – Caribbean <input type="checkbox"/>
Black or Black British – African <input type="checkbox"/>
Other Black Background <input type="checkbox"/>
Asian or Asian British – Indian <input type="checkbox"/>
Asian or Asian British – Pakistani <input type="checkbox"/>
Asian or Asian British – Bangladeshi <input type="checkbox"/>
Chinese or Other Ethnic Background – Chinese <input type="checkbox"/>
Other Asian Background <input type="checkbox"/>
Mixed – White and Black Caribbean <input type="checkbox"/>
Mixed – White and Black African <input type="checkbox"/>
Mixed – White and Asian <input type="checkbox"/>
Other Mixed Background <input type="checkbox"/>
Other Ethnic Background <input type="checkbox"/>
Not Known <input type="checkbox"/>
Information Refused <input type="checkbox"/>

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 <input type="checkbox"/>
You have dyslexia <input type="checkbox"/>
You are blind/partially sighted <input type="checkbox"/>
You are deaf/have a hearing impairment <input type="checkbox"/>
You are a wheelchair user or have mobile difficulties <input type="checkbox"/>
You need personal care support <input type="checkbox"/>
You have mental health difficulties <input type="checkbox"/>
You have an unseen disability, e.g. diabetes, epilepsy, asthma <input type="checkbox"/>
You have two or more of the above disabilities/special needs <input type="checkbox"/>
You have a disability not listed above
Please Specify:

