

Equality Monitoring Form

In order to ensure that we provide the right services and to ensure that we avoid discriminating against any section of our community, it is important for us to gather the following information. No personal information will be released when reporting statistical data and data will be protected and stored securely in line with data protection rules.

This information will be kept confidential. Please try to answer all the questions

<p>1. What sex are you?</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say</p> <p>2. Is your gender identity the same as the sex you were assigned at birth?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to say</p> <p>3. How old are you?</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 15%;">Example</td> <td>42</td> </tr> <tr> <td>Yours</td> <td style="height: 20px;"></td> </tr> </table> <p><input type="checkbox"/> Prefer not to say</p> <p>4. Do you belong to any religion?</p> <p><input type="checkbox"/> Buddhism <input type="checkbox"/> Christianity <input type="checkbox"/> Hinduism <input type="checkbox"/> Islam <input type="checkbox"/> Judaism <input type="checkbox"/> Sikhism <input type="checkbox"/> No Religion <input type="checkbox"/> Other (Please specify in the box below)</p> <div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <p><input type="checkbox"/> Prefer not to say</p> <p>5. Which country were you born in?</p> <div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <p><input type="checkbox"/> Prefer not to say</p>	Example	42	Yours		<p>6. What is your ethnic group?</p> <p>Asian or Asain British:</p> <p><input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asain Background (please specify)</p> <div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <p>Black or Black British:</p> <p><input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Other Black background (please specify)</p> <div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <p>Mixed or multiple ethnic groups:</p> <p><input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Other mixed background (please specify)</p> <div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <p>White:</p> <p><input type="checkbox"/> English/Welsh/Scottish/Nothern Irish/British <input type="checkbox"/> Irish <input type="checkbox"/> Gypsy or Irish Traveller <input type="checkbox"/> Other White background (please specify)</p> <div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <p>Other ethnic groups:</p> <p><input type="checkbox"/> Arab <input type="checkbox"/> Any other ethnic group (please specify)</p> <div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <p><input type="checkbox"/> Prefer not to say</p>
Example	42				
Yours					

7. Do you consider yourself to be disabled?

- Yes No
 Prefer not to say

Type of impairment:

Please tick all that apply

- Physical or mobility impairment**
(such as using a wheelchair to get around and/or difficulty using arms)
- Sensory impairment**
(such as being blind/having a serious visual impairment or being deaf/having a serious hearing impairment)
- Mental health condition**
(such as depression or schizophrenia)
- Learning disability**
(such as Downs syndrome dyslexia or cognitive impairment such as autism or head injury)
- Long term condition**
(such as cancer, HIV, diabetes, chronic heart disease or epilepsy)
- Prefer not to say

8. Do you look after, give any help or support to a family member, friend or neighbour because of a long term physical disability, mental ill-health or problems related to age?

- Yes No
 Prefer not to say

9. Are you pregnant?

- Yes No
 Prefer not to say

10. Have you given birth in the last 6 months?

- Yes No
 Prefer not to say

11. Please select the option that best describes your sexual orientation.

- Bisexual (both sexes)
 Homosexual/Gay/Lesbian (same sex)
 Heterosexual/straight
 Other
 Prefer not to say