



Membership Form

Name			
Address			
Post Code		Telephone Number	
Date of Birth		Next of Kin (name and telephone no.)	
Email address			
Are you a carer? (Do you care for a relative at home?)			

We are required by our funders to collect certain information about our members. We also want to make sure that our services are delivered fairly. You do not have to answer these questions, and if you choose not to, this won't make any difference to the service you receive. The information will be used for statistical purposes and will be confidential. Your name will not be linked with the information you give us.

Housing (Please tick which applies to you)					
Council	<input type="checkbox"/>	Private	<input type="checkbox"/>	Housing Association	<input type="checkbox"/>
No. of Bedrooms	<input type="checkbox"/>	Live Alone	Yes / No	Is it sheltered housing?	Yes / No

Name of your GP	
GP's Practice	

P.T.O.

Health

Would you describe yourself to have any of the following:

	Yes	No
Mental Health Problems	<input type="checkbox"/>	<input type="checkbox"/>
Physical Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Learning Difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>

Please give any other relevant details about your health:

What gender are you?

Male Female

Do you consider yourself disabled?

Yes No

How would you describe your ethnicity?

White British		White Other (please specify)	
Black British		Black Other (please specify)	
Asian British		Asian Other (please specify)	
Prefer not to say		Mixed (please specify)	
		Other (please specify)	

I give my permission for these details to be held in an electronic database by OPAL. This will enable me to take part in OPAL activities, and receive a newsletter.

Signed _____ Date _____