

OPAL Membership Form

Title		Preferred First Name	
Surname		Legal First Name (if different)	
Address			
Post Code		Telephone Number	
Date of Birth		Emergency contact (name & tel no.)	
Email address			
Are you a carer? (Do you care for a relative at home?)			
Name of your GP			
GP's Practice			
Do you have any allergies? If so please give us details			
Do you have any mobility problems? If so please give us details <small>For example: do you need to sit in the front seat of a car; do you need a walking aid etc.</small>			
Do you live alone?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Are you a council tenant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
What is your gender?	Male <input type="checkbox"/>	Female <input type="checkbox"/>	

It may be necessary to request for extra information regarding your health needs in order that we can assess whether we can meet them in an appropriate manner. If we feel we are unable to meet your needs appropriately, you may not be able to access some OPAL activities.

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 _____

We sometimes take photographs of our members at OPAL activities for publicity. If you DON'T want your photo used by OPAL, tick this box.

To receive your newsletter in large print, tick this box

To receive your newsletter on cassette, tick this box

£10 annual membership fee paid.

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. The information will be used for statistical purposes, and will be confidential. You do not have to answer these questions, and your responses will make no difference to the service you receive.

Do you consider yourself to have any of the following disabilities?

	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 relevant details about your health:

What is your ethnic origin?

- | | | |
|--|---|--|
| <input type="checkbox"/> Prefer not to say | <input type="checkbox"/> Asian Pakistani | <input type="checkbox"/> Asian Bangladeshi |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Black African | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Black Caribbean | <input type="checkbox"/> White British | <input type="checkbox"/> White Irish |
| <input type="checkbox"/> Mixed race | <input type="checkbox"/> Other (please specify) | |
| <input type="checkbox"/> White -other background | | |

What is your religion?

- | | | |
|--|---------------------------------|-----------------------------------|
| <input type="checkbox"/> Prefer not to say | <input type="checkbox"/> Baha'i | <input type="checkbox"/> Buddhist |
| <input type="checkbox"/> No religion | <input type="checkbox"/> Hindu | <input type="checkbox"/> Jain |
| <input type="checkbox"/> Christian | <input type="checkbox"/> Muslim | <input type="checkbox"/> Sikh |
| <input type="checkbox"/> Jewish | | |
| <input type="checkbox"/> Any other religion or belief (please specify) _____ | | |

Which of the following best describes your sexual orientation?

- | | | |
|--|----------------------------------|--|
| <input type="checkbox"/> Prefer not to say | <input type="checkbox"/> Gay man | <input type="checkbox"/> Lesbian/Gay woman |
| <input type="checkbox"/> Heterosexual/straight | <input type="checkbox"/> Other | |
| <input type="checkbox"/> Bisexual | | |

Is your gender identity the same as the gender you were originally assigned at birth?:

- Prefer not to say Yes No