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| **MONITORING QUESTIONNAIRE**  **Please complete and return in separate envelope along with completed application form.**   |  | | --- | | **NATIONAL INSURANCE NUMBER:** | | **AGE: Please enter your date of birth:**  // | | **GENDER: I am -** Male ❒ Female ❒ | | **COMMUNITY BACKGROUND:**  **I am –**  A member of the Protestant Community❒  A member of the Roman Catholic Community ❒  Not a member of either the Protestant or the Roman Catholic Communities❒ | | **DISABILITY**  **I have -**  No disability ❒  A physical impairment, such as difficulty using arms or mobility requiring a wheelchair or crutches ❒  A sensory impairment, such as blind/visual impairment or deaf/hearing impairment ❒  A mental health condition, such as depression or schizophrenia ❒  A learning disability, such as Down’s syndrome, dyslexia or cognitive impairment such as autism ❒  A long standing illness, such as cancer, HIV, diabetes, chronic heart disease or epilepsy ❒  Other ❒ Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **MARITAL STATUS**  **I am -**  Single (never married) ❒  Married (living with spouse) ❒  Married (separated) ❒  Civil partnership (same sex) ❒  Divorced ❒  Widowed ❒  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **RACE, COLOUR OR ETHNIC/NATIONAL ORIGINS**  **I am -** White ❒Chinese ❒Irish Traveller ❒Indian ❒Pakistani ❒Bangladeshi ❒  Black African ❒Black Caribbean ❒Black Other ❒Please specify­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mixed Ethnic Group ❒ Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other ❒ Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **NATIONALITY**  Please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **DEPENDENTS/CARING RESPONSIBILITIES**  Please indicate if you have dependents or persons you have caring responsibility for (if anyone):  **No. dependents or caring responsibilities: -**   |  |  | | --- | --- | | Child or children |  | | Disabled person(s) |  | | Elderly person(s) |  |  |  |  | | --- | --- | | Other |  | | | **ADVERTISING**  Please name any newspapers and/or websites where you learned of this job: | |