**School of Life Sciences**

**Module Application Form**



Please type or use block capitals to complete **ALL** sections of this form

**Title and code of module as provided by IBMS:**

**Campus/Site:**

**Start Date:**

**Please select Level** -Level 4 *or* Level 5 *or* Level 6 *(delete as appropriate)*

**Number of Credits** - 0 15 30 (*delete as appropriate*)

**1. Personal Details**

Surname Title Mr/Mrs/Miss/Ms (*delete as appropriate*)

First names (in full) Male/Female (*delete as appropriate*)

Maiden name *(if applicable)*

Home address

Post code

Telephone number Email address

Date of birth

Country of birth Nationality (as on passport)

**\*Employer:**

**Employer Address**:

**\*NMC/HCPC NUMBER** *(if applicable)*

**Are you an IBMS member** *Yes/No*(*delete as appropriate*)

**If Yes please supply your IBMS Number**

**2**

**.**

**Proposed source of funding**

Health Education

Employer Funded

Self-Funded

Other (please specify)

Has this funding been approved? Yes

No

If you have confirmed funding through your workplace, please complete this section:

Name and position of authorising member of staff (print name):

Signature of authorising member of staff: ……………............................……..…………… Date: ………………….

If you require an invoice for your fees to be sent to your employer, please give contact details and address below:

1. **Academic and professional qualifications (if applicable)**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of award | Awarding Institution | Course Title/Subject | Result |
|  |  |  |  |

Have you previously studied at the University of Essex? Yes No

1. **Employment History (past and current)**

|  |  |  |
| --- | --- | --- |
| Dates of employment | Place of employment | Job Title |
|  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Clinical profession** |  | **Please give job title** |  | **For Office use**  **(NMC/HCPC recordable modules only)**    First level/Second Level Registration  (Delete as appropriate for NMC PIN)    Registration confirmed by: ……………    Approved by Module/Programme Lead    …………………………Date……………… |
| Biomedical Student |  |  |
| Allied Health Professional |  |  |
| Health Care Scientist |  |  |
| Other |  |  |
| Unknown |  |  |

1. **Have you applied to study at this University before?**  If so, please give details

Any other comments relevant to this application?

**Data Protection Act 1998**

The University of Essex has a notification under the Data Protection Act 1998 to enable it to hold and process personal data about its students for the purposes of maintaining their academic and related records. The information supplied on this form will be held under the terms of the Act; it will be kept secure and accurate and will only be disclosed to people who have a need to know in accordance with the Act. *Your attendance and Examination Board ratified module marks will be shared with your sponsoring Trust. If you do not wish this to happen, you are responsible for asking your line manager to communicate with the School to this effect.*

***Please note that the information on this application form is required for registration purposes only.***

Applicant’s signature …………………………………………...............… Date…………………….……...

**\*Line Manager’s signature**..………………………………..............…… Date…………………….……...

**\*Print Name**

|  |  |
| --- | --- |
| **DBS complete and verified by Employer** | **Yes/No** |
| **I confirm that this applicant is of good health and character** | **Yes/No** |

Education Liaison Manager’s signature…….....................................………………….Date………………….….….....

For applicants funded from NHS Contracts, please return this to your Education Liaison Manager (who will authorise it and return it to Life Sciences on your behalf); for all other applicants, please sign and confirm payment details, then return the form to the Life Sciences Contracts Administrator (esmbs@essex.ac.uk)

**\*essential to complete**

**EQUAL OPPORTUNITIES**

This form will be detached. Please complete and return it with your application.

The information you provide will be held on database and will only be used for statistical analysis by HESA and certain other bodies that deal with the funding of education.

Thank you.

**PERSONAL DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name |  | Title (e.g. Mr, Mrs, Miss, Dr\_ |  |
| First name(s) (for official purposes) |  | Preferred first name |  |
| Date of Birth |  | Gender |  |
| Your nationality |  |  |  |

Your ethnicity (please tick)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **White** |  |  | **Asian or Asian British** |  |  |
| White British |  | 11 | Asian or Asian British - Indian |  | 31 |
| White Irish |  | 12 | Asian or Asian British - Pakistani |  | 32 |
| Other White Background |  | 19 | Asian or Asian British -Bangladeshi |  | 33 |
| **Black or Black British** |  |  | Other Asian background |  | 39 |
| Black or Black British - Caribbean |  | 21 | **Mixed** |  |  |
| Black or Black British - African |  | 22 | Mixed - White and Black Caribbean |  | 41 |
| Other Black background |  | 29 | Mixed - White and Black African |  | 42 |
| **Chinese** |  |  | Mixed - White and Asian |  | 43 |
| Chinese |  | 34 | Other Mixed background |  | 49 |
| **Other Ethnicity** |  |  | **I do not wish to disclose my ethnicity** |  | 98 |
| Other Ethnic background:  Description: |  | 80 |  |  |  |

**Disability** (please tick any which you consider apply to you).

In addition to providing information for HESA, completion of this section will assist the University in understanding the needs and requirements of disabled staff and also allow us to work towards meeting our obligations under the Disability Equality Duty.

|  |  |  |
| --- | --- | --- |
| 00 |  | No known disability |
| 51 |  | Specific learning disability (such as dyslexia or dyspraxia) |
| 52 |  | General learning disability (such as Down's syndrome) |
| 53 |  | Cognitive impairment (such as autistic spectrum disorder or resulting from head injury) |
| 54 |  | Long-standing illness or health condition (such as cancer, HIV, diabetes, chronic heart disease, or epilepsy) |
| 55 |  | Mental health condition (such as depression or schizophrenia) |
| 56 |  | Physical impairment or mobility issues (such as difficulty using arms or using a wheelchair or crutches) |
| 57 |  | Deaf or serious hearing impairment |
| 58 |  | Blind or serious visual impairment |
| 96 |  | Other type of disability |
| 97 |  | I do not wish to provide this information |