

**Medical Work Experience Programme – Application Form 2020**

Please complete all sections in black ink

Please note that these application forms are kept for a 6 month period from the date of Work Experience taking place and are then destroyed

<b>Last Name:</b>	
<b>First Name(s):</b>	
<b>Date of Birth:</b>	<b>Please note that you must be 17 years of age at the time of the placement taking place.</b>
<b>If you are related to an employee of the Trust, please give details:</b>	
<b>Home address:</b>	<p><b>Post Code:</b> _____ <b>Telephone No:</b> _____</p> <p><b>Email Address:</b> _____</p>
<b>School/College name and address:</b>	<p><b>Post Code:</b> _____ <b>Telephone No:</b> _____</p>
<b>Name of School/College Work Experience Coordinator</b>	<p><b>Name:</b> _____</p> <p><b>Email Address:</b> _____</p> <p><b>Tel:</b> _____</p>
<b>Course dates in order of preference</b>	<p>1. _____</p> <p>2. _____</p> <p><b>(Week 1) 22<sup>nd</sup> – 26<sup>th</sup> June 2020</b></p> <p><b>(Week 2) 29<sup>th</sup> June – 3<sup>rd</sup> July 2020</b></p>

**Please list all the subjects/courses taken or being taken and grades**

<b>Subject</b>	<b>Dates</b>	<b>Level</b>	<b>Grades Achieved (or predicted)</b>
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<b>GCSE:</b>			
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<b>A-level/AS level:</b>			
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## **Supporting Information**

This is your opportunity to promote yourself to identify why you would like to gain some work experience in the NHS. Please use this space to provide any supporting information to go with your application.

**Please indicate what you hope to do when you leave school/college and explain why this is your chosen career?**

**What do you hope to gain from the Careers Within Medicine Programme and how do you think this will help with your chosen career?**

**Please indicate any other relevant information or experience, which may support your application for this programme.**

Signature of Applicant: ..... Date: .....

Signature (parent/guardian – if applicant is under 18): .....

Date: .....

Please note that by signing this Agreement, you are agreeing that you understand that your son/daughter may observe a real patient operation in the Operating Theatres or Day Case Unit.

**ONLY COMPLETE THIS BOX IF YOU DO NOT WANT YOUR SON/DAUGHTER TO OBSERVE AN OPERATION**

I do not agree to my son/daughter observing a real patient operation.

Signature of parent/guardian – if applicant is under 18): .....

Date: .....

Signature (of Representative of your School/College): .....

Date: .....

This form should be returned along with the equal opportunities monitoring form to: Work Experience Co-ordinator, Undergraduate Centre, North Block 2<sup>nd</sup> Floor. Russells Hall Hospital, Pensnett Road, Dudley, West Midlands, DY1 2HQ by 31/03/2020. Forms can also be scanned in once completed and sent to [dgft.medicalwork.experience@nhs.net](mailto:dgft.medicalwork.experience@nhs.net)

Application forms received after this date will not be considered.

Please note that forms without completed signatories will be returned to the applicant.

## Medical Work Experience Programme 2020 More Information About You

Are you male or female?                      Male     Female   

How would you describe your ethnic background?

a) White

British

Irish

Other (please describe):.....

b) Mixed

White & Black Caribbean

White & Black African

White & Asian

Other (please describe):.....

c) Asian or Asian British

Indian

Pakistani

Bangladeshi

Other (please describe):.....

d) Black or Black British

Caribbean

African

Other (please describe):.....

e) Other Ethnic Group

Chinese

Other (please describe):.....

Are you disabled?  
(if yes please tick all that apply)

Sensory impairment

Mobility disability

Learning disability

Mental health

Other (please describe)

Please indicate your religion or belief

Atheism

Buddhism

Christianity

Hinduism

Islam

Jainism

Judaism

Sikhism

Other

I do not wish to disclose  
my religion