

Mystery Shopper

Application form



Please complete this form if you would like to become a mystery shopper. The information you provide will be treated confidentially and only used to contact you with regard to this project.

A. Your contact details

Title (please delete as appropriate):	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Other (please detail) <input type="checkbox"/>
Your full name:				
Your address:				
Postcode:				
Email address:				
Telephone:	Mobile:			

B. About you

Patient	<input type="checkbox"/>	Member of a community voluntary organisation	<input type="checkbox"/>
Family member / relative of patient	<input type="checkbox"/>	Carer	<input type="checkbox"/>
Local resident	<input type="checkbox"/>	Other (please specify in the space below)	<input type="checkbox"/>

C. Special requirements and assistance

Please let us know if you require any assistance or have any special requirements.

Do you have any special requirements? (please tick as appropriate)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please describe below.		

D. Why are you interested in the role?

Please use the space below to tell us briefly why you would like to become a mystery shopper?



E. Helping us to understand more about the patients and the community we serve

This information is used to help us monitor the effectiveness of our equality and diversity policies and to help comply with legal requirements. Please take a few minutes to complete this section, to help us check that we are reaching all parts of the community.

Ethnic background (please tick one box)

White	<input type="checkbox"/>	Asian or Asian British	<input type="checkbox"/>	Black or Black British	<input type="checkbox"/>
Chinese or other ethnic group	<input type="checkbox"/>	Mixed	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>

Age (please tick one box)

Under 18	<input type="checkbox"/>	18 – 34	<input type="checkbox"/>	35 – 54	<input type="checkbox"/>	55 – 74	<input type="checkbox"/>	75+	<input type="checkbox"/>
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Sexual orientation

How would you describe your sexual orientation?

Bisexual	<input type="checkbox"/>	Gay man	<input type="checkbox"/>	Gay woman / lesbian	<input type="checkbox"/>
Straight / heterosexual	<input type="checkbox"/>	Other	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>

Religion (please tick one box)

Christian (including Church of England, Catholic, Protestant and all other Christian denominations)	<input type="checkbox"/>	Muslim	<input type="checkbox"/>
Buddhist	<input type="checkbox"/>	Sikh	<input type="checkbox"/>
Hindu	<input type="checkbox"/>	Other religion, please state:	<input type="checkbox"/>
Jewish	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>

Disability (please tick one box)

Do you consider yourself to have a disability that is recognised by the Disability Discrimination Act (1995)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Prefer not to say <input type="checkbox"/>
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Please return this form to:

Freepost SEA 14501
 NHS Bexley CCG
 Patient Experience Team
 221 Erith Road,
 Bexleyheath
 DA7 6BR

