

MENTOR TRAINING CENTRE LTD

MODERN APPRENTICESHIP APPLICATION FORM

PLEASE COMPLETE ALL SECTIONS IN BLOCK CAPITAL LETTERS IN BLACK INK,
AND RETURN TO:-

MENTOR TRAINING CENTRE, 3rd FLOOR, 176 BATH STREET, GLASGOW, G2 4HG

Personal Details

Mr Mrs Miss Ms

Full Name (as printed on Birth/Marriage Certificate):

Previous Name/Maiden Name (if applicable):

D.O.B. Day Month Year Age:

Address:

Post Code:

Home Telephone Number:

Mobile Telephone Number:

E-mail:

Preferred Method of contact:

SMS Text or Email

National Insurance Number:

Name of Emergency Contact:

Telephone Number:

Relationship:

Education/Qualification/Training

Name of School attended:

Leaving Date:

Qualifications achieved (include levels):

Name of College attended:	From:	To:
Qualification Achieved (include levels):		

Have you been on a training programme before?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, with which Training Centre:			
Type of Training:	From:	To:	
SCQF Level Achieved:	None <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
		6 <input type="checkbox"/>	7 <input type="checkbox"/>

Eligibility Criteria for Public Funding

Are you on any other publicly funded education or training programme or further/higher education course?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you an overseas National?		Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please provide information about your current employment

Duration with current employer:	less than 1 month <input type="checkbox"/>	1-3 <input type="checkbox"/>	4-6 <input type="checkbox"/>	7-9 <input type="checkbox"/>	10-12 <input type="checkbox"/>	over a year <input type="checkbox"/>
Duration in current job role with current employer:	less than 1 month <input type="checkbox"/>	1-3 <input type="checkbox"/>	4-6 <input type="checkbox"/>	7-9 <input type="checkbox"/>	10-12 <input type="checkbox"/>	over a year <input type="checkbox"/>
What were you doing before you started working for this employer?						

Please provide information about previous full/part time employment

Business/Organisation name:	Start & End Dates:	Duties/Tasks undertaken:

Interests/Hobbies

Leisure activities/member of any clubs, programmes, any awards obtained or voluntary service:-
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Do you have any allergies or illnesses which could affect the type of work you may do?
(Please provide details)

Data Protection Statement

In compliance with the Data Protection Act 1998, I hereby give my consent for my personal data to be processed, used and disclosed to third parties by Mentor Training Centre Ltd on the understanding that such processing, use or disclosure:-

- Is conducted in a fair and lawful manner and in accordance with the Data Protection Act 1998
- Is for purposes in furtherance of and compatible with my employment and/or training and development objectives
- That appropriate technical and administrative measures shall be taken to prevent unauthorised access to or accidental loss of the data

The information provided on this form is, to the best of my knowledge, true and correct.

I will notify Mentor Training Centre should any of my details or circumstances change during the course of my training

Signed:

Date:

Dental Practice Details

Business/Practice Name:

Address:

Post Code:

Telephone Number:

Supervisors Name:

E-mail address:

Start Date:

National Training Programmes Equality Monitoring Form

Note to Training Providers:

Please read the document “[Equality Monitoring in the Modern Apprenticeship and Employability Fund 2017 – 2018](#). Guidance document for training providers on how to use the Equality Monitoring Form and record in FIPS or CTS”

This form must be printed out and completed by the participant.

You must ensure that:

- both Sections A and Section B of this SDS National Training Programmes Equality Monitoring Form are given to the participant before asking the participant any of the questions in Section A
- the participant reads and signs the form in this Section B. The completed and signed section B must be retained at all times by the training provider for inspection

Section A of this form must be securely disposed of immediately once the information has been entered into the CTS or FIPS secure recording systems.

Section A

National Training Programme	Modern Apprenticeship <input type="checkbox"/>
	Employability Fund <input type="checkbox"/>
	Other <input type="checkbox"/>

1. Ethnic group

Please read the list below and tick the box that most closely describes you.

White	
Scottish	<input type="checkbox"/>
Other British	<input type="checkbox"/>
Irish	<input type="checkbox"/>
Other white background	<input type="checkbox"/>
Mixed ethnic background	<input type="checkbox"/>
Asian, includes Asian Scottish and Asian British	
Pakistani	<input type="checkbox"/>
Indian	<input type="checkbox"/>
Bangladeshi	<input type="checkbox"/>
Chinese	<input type="checkbox"/>
Other Asian Background	<input type="checkbox"/>
Black, includes Black Scottish & Black British	
African	<input type="checkbox"/>
Caribbean	<input type="checkbox"/>
Other black background	<input type="checkbox"/>
Other ethnic background	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>
Not known	<input type="checkbox"/>

2. Religion or Belief or none

Please indicate your religion or belief from the following options

None	<input type="checkbox"/>
Church of Scotland	<input type="checkbox"/>
Roman Catholic	<input type="checkbox"/>
Other Christian	<input type="checkbox"/>
Muslim	<input type="checkbox"/>
Buddhist	<input type="checkbox"/>
Sikh	<input type="checkbox"/>
Jewish	<input type="checkbox"/>

Hindu	<input type="checkbox"/>
Pagan	<input type="checkbox"/>
Other	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>

3. Transgender

Have you ever identified as transgender?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>

4. Care Experience

Have you ever been in care*?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>

* In care means you are or were formally looked after by a local authority, in the family home (with support from social services or a social worker) or elsewhere, for example, in foster care, residential/secure care, or kinship care (with family friends or relatives).

4. Sexual Orientation

Do you consider yourself to be?

Heterosexual/ Straight	<input type="checkbox"/>
Gay/ Lesbian	<input type="checkbox"/>
Bisexual	<input type="checkbox"/>
Other	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>

5. Offending History

Have you ever been subject to criminal justice measures and/or convicted of a crime?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>

6. Disability

The information you provide in this section will help us provide an inclusive environment for disabled people, by identifying and removing barriers in our practices.

1. Do you have an impairment, health condition or learning difficulty?*

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>

*lasting or expected to last 12 months or more

2. If you have an impairment, health condition or learning difficulty, please select all those on the list that apply.

You have a social/communication impairment such as a speech and language impairment or Asperger's syndrome/other autistic spectrum disorder, or cognitive impairment	<input type="checkbox"/>
You are blind or have a visual impairment uncorrected by glasses	<input type="checkbox"/>
You are deaf or have a hearing impairment	<input type="checkbox"/>
You have a long standing illness or health condition such as cancer, HIV, diabetes, chronic heart disease, or epilepsy	<input type="checkbox"/>
You have a mental health difficulty, such as depression, schizophrenia or anxiety disorder	<input type="checkbox"/>
You have a specific learning difficulty such as dyslexia, dyspraxia or AD(H)D	<input type="checkbox"/>
You have a physical impairment or mobility issues, such as difficulty using your arms or using a wheelchair or crutches	<input type="checkbox"/>
You have a disability, impairment or medical condition that is not listed above	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>

Section B

Privacy Statement

The responses you provide to the questions set out in Section A of this Equality Monitoring Form are required for the following purpose (“Purpose”):-

Under the Equality Act 2010, SDS is required to ensure equality of access to its services. SDS is therefore required to monitor participation within its National Training Programmes by ‘protected characteristics’. ‘Protected characteristics’ are defined in the Equality Act, and include the categories set out in the questions in Section A of the form above. SDS publishes the data in an anonymised form (which does not identify any individual), in accordance with its obligations under the Equality Act.

Your responses to the questions in Section A above (“Equalities Monitoring Data”) will be provided to SDS by your Training Provider. SDS shall use your Equalities Monitoring Data only for the Purpose, and shall not disclose your Equalities Monitoring Data to any organisation or individual. Your Training Provider shall securely dispose of Section A as soon as your responses in Section A have been entered into the SDS FIPs or CTS secure recording system.

Training Provider to ensure that:-

- both Sections A and Section B of this SDS National Training Programmes Equality Monitoring Form are given to the Participant before asking the Participant any of the questions in Section A,
- the Participant reads and signs the form in this Section B. The completed and signed section B must be retained at all times by the Training Provider for inspection, and
- Section A is securely disposed of as soon as the Participant’s responses in Section A have been entered into the SDS CTS or FIPs secure recording system.

Participant Signature	
Print Name	
Date	

Thank you for completing this form