

## Apprenticeship Application Form

<b>Name:</b>		<b>Email:</b>	
<b>Contact No:</b>		<b>Bleep:</b>	
<b>Job Title:</b>		<b>Department:</b>	
<b>Pay Band:</b>		<b>Assignment No:</b>	
<b>Line Manager:</b>			

**Weekly hours and contract type:**

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**If on Fixed Term Contract:**

<b>Start Date:</b>	<b>End Date:</b>
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I would like to apply for:

**Apprenticeship course and level:**

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**Previous qualifications and year of completion:**

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**Have you completed the Care Certificate if relevant to your role?**

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**Have you achieved a Level 2 qualification in English?**

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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**Have you achieved a Level 2 qualification in maths?**

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Acceptable Level 2 qualifications are:  
GCSE English/maths grade A\*-C, Functional Skills English/maths Level 2.

### Eligibility information

**Nationality:**

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**Have you been resident in the UK for the last 3 years?**

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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**If no, where have you been resident?**

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**Are you currently enrolled on another course or apprenticeship?**

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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**RELEVANCE OF APPRENTICESHIP TO YOUR ROLE:** Please discuss the following with your Line Manager.

How will this apprenticeship develop the skills and knowledge you need for your job role?

Describe how this apprenticeship will help you demonstrate one of the Organisation's values: (e.g. at Papworth Hospital these are leading with care, instilling innovation, feeling valued, encouraging excellence)

Describe how you will complete your apprenticeship in the time allocated.

Are you aware of any reasons why you cannot commit to completing this course? If yes, please give details.

Do you have any barriers to learning and if so, what resources will you require to help you succeed?

**Applicant**

All information provided on this form is accurate and I confirm that I am able to commit to the requirements of this qualification. I also confirm that I am up to date with all mandatory training. I am happy for my details to be shared with the training provider for this course.

Print Name:

Date:

Signature:

**Line Manager**

I have considered the eligibility criteria for apprenticeships and support this application. I am happy to support this employee through: additional support, guided learning, wider employer experience, assessor visits and to allow time during contracted working hours equating to 20% "off-the-job" training to undertake course related work.

Print Name:

Date:

Signature:

Contact number:

Email address:

Please send completed form to:

XXX

**MONITORING INFORMATION**

This section will be detached from your application form and will be used for monitoring purposes only.

NHS Organisations recognise and actively promote the benefits of a diverse workforce and are committed to treating all employees with dignity and respect regardless of race, gender, disability, age, sexual orientation, religion or belief.

Date of Birth	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> I do not wish to disclose this information

I would describe my ethnic origin as:		
<p><b>Asian or Asian British</b></p> <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Any other Asian background	<p><b>Mixed</b></p> <input type="checkbox"/> White & Asian <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> Any other mixed background	<p><b>Other Ethnic Group</b></p> <input type="checkbox"/> Chinese <input type="checkbox"/> Any other ethnic group  <input type="checkbox"/> I do not wish to disclose this information
<p><b>Black or Black British</b></p> <input type="checkbox"/> African <input type="checkbox"/> Caribbean <input type="checkbox"/> Any other Black background	<p><b>White</b></p> <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other White background	

I would describe my sexual orientation as:
<input type="checkbox"/> Lesbian <input type="checkbox"/> Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Heterosexual <input type="checkbox"/> Other <input type="checkbox"/> I do not wish to disclose this information

Do you consider yourself to have a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not wish to disclose this information
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