



# FURTHER EDUCATION LEARNER APPLICATION FORM

Please place  
photograph of  
learner here

Learner name:

Preferred to be known as:

School name: (if appropriate)

Name and Signature of person completing this form  
and their relationship to learner:

Date form completed:

Date placement required from:

Type of Education placement required:

- |                                            |                                              |
|--------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Day               | <input type="checkbox"/> 5 Day Residential   |
| <input type="checkbox"/> 7 Day Residential | <input type="checkbox"/> 52 Week Residential |

Do you want to study at Portland's main campus in Mansfield?

Or are you interested in City Learning?

At Wollaton Hall

or Antenna

Not sure

**FOR OFFICE USE ONLY**

Date received:

## THANK YOU FOR YOUR INTEREST IN PORTLAND COLLEGE

Please complete this application form with as much information as you can, the more details we have, the better we can support you.

**Please ensure that you enclose your most recent Education, Health and Care Plan (EHC plan).**

**Failure to evidence information through your EHC plan or this application form will delay your application being processed.**

Once we have received your completed application form and EHC plan, our Admissions team will contact you to arrange an assessment.

After this assessment, should our Multi-Disciplinary Team feel that we can support you and your needs, we will contact you to offer a placement which will be subject to funding. Should this offer be accepted by yourselves, we will then create an Initial Assessment Report which will be sent to your Local Authority as part of a funding request. You will then be contacted directly by your Local Authority to inform you if funding has been agreed and your place at Portland College confirmed.

If you would like to extend your personal and social progression around your education programme, we have Portland Freedom based on the same campus. Portland Freedom is assessed and funded separately to the education provision.

Portland Freedom has been designed to meet your specific individual requirements, offering Day Centre services, Short Breaks and an Independent Living service, all with a range of bespoke and structured schedules.

For more information, please contact the Freedom team on **01623 494322**.

# CONTACT INFORMATION

Learner full name:

Known as:

Date of birth:

Address:

Telephone number:

Are you a Looked After Child, or in the care of your Local Authority? Yes

No

Primary Contact Person

Name:

Relationship:

Address:

Telephone:

Mobile:

Email:

Emergency contact? Yes

No

Parental Responsibility? Yes

No

If No to either of these questions, please provide details of who is:

Please tick here if you would **NOT** like to be contacted via email or text regarding College events and promotions

GP Contact

Doctors name:

Surgery:

Address:

Telephone:

Religious or Cultural needs:

NHS number:

Medical Exemption number:

## CONTACT INFORMATION continued

School Contact

tick if not relevant

Name:

Role:

Address:

Telephone:

Email:

Social Worker

tick if not relevant

Name:

Address:

Telephone:

Email:

Personal Advisor or SEN contact at your Local Authority

tick if not relevant

Name:

Address:

Telephone:

Email:

Are you currently receiving any of the following therapies?

Physiotherapy

Occupational Therapy

Speech and Language Therapy

Other - please state:

Who, or where, originally referred you to Portland College? (please provide full contact details if relevant)

# INFORMATION ABOUT YOU

What is your disability?

Green horizontal lines for text entry.

How does it affect your learning?

Green horizontal lines for text entry.

Please tell us about your personality, including your likes and dislikes.

Green horizontal lines for text entry.

# INFORMATION ABOUT YOU continued

What would you like to study at Portland College?

Please choose **one** study programme and also the subjects within the programme that interest you.

## Land Based and Trade Industries

- Horticulture
- Small Animal Care
- Light Manufacturing
- Production and Logistics
- Painting and Decorating
- Basic Joinery
- Basic Wet Trade Skills

## Design, Technology and Retail Industries

- Business Studies, Retail and Administration
- Arts, Media and Marketing
- Customer Services

## Service and Leisure Industries

- Sport and Leisure
- Hospitality and Catering
- Care Services
- Salon Services

## Communication and Choice (Pre-entry)

If you are working at pre-entry level, there will be a range of session topics for you to choose from when you arrive at college.

# INFORMATION ABOUT YOU continued

What are your future aspirations?


Have you taken part in any work experience or completed a work placement?

Yes      No

If yes, please provide details, including whether this was at school or with a company:


## EDUCATIONAL DETAILS

You may wish to ask your school to help you complete this page.

### What have you achieved so far?

Please detail your examination history and any other accredited achievements. We use this information to make sure that you have access to the appropriate study programme.

Title/Course	Awarding Body	Level(GCSE/Entry/Preentry)	Grade/Expected Grade

What else have you achieved? (e.g. communication, decision making, problem solving, Duke of Edinburgh etc)


How do you like to record your work? (e.g. symbols, words, audio)


What are your current levels in the following areas:  
(If you do not know this, then please ask your school contact)

English:

Maths:

Vocational Areas:

--

Please let us have any certificates you have achieved so far with this application.



# CONSENT AND BEST INTEREST DECISIONS

We now require parental consent to access confidential information around academic levels and accessing the most recent Education Health and Care Plan (EHCP) information from your local authority.

I consent to my son/daughter's EHC Plan and academic levels to be shared with the Assessment Triage Team at Portland College during the assessment process. The college's privacy statement can be found on our website: [www.portland.ac.uk](http://www.portland.ac.uk)

Name of Learner:

Date of Birth:

Parent/Carer Name:

Relationship to Learner:

Date:

Signature:

Have there been any Best Interest decisions already made on behalf of the applicant?

Yes

No

If YES, please state below for what decision (e.g. personal care, financial, medication.)

Blank area for providing details of Best Interest decisions.

# BEHAVIOUR

Please describe some examples of any behaviours that may challenge your learning and others.  
(please include all levels of behaviour)

---

---

---

When was the last occurrence of behaviour?

---

What triggers this behaviour? (e.g environment, other learners, change etc)

---

---

---

---

---

How often do these behaviours occur?

Never  Occasionally  Often  Very Often

What are the early signs that staff need to be aware of before any behaviours occur? (pacing, crying, change in facial expression etc)

---

---

What strategies help to support with the behaviour to try and stop it? (e.g calm approach, reinforcements/rewards, proactive strategies, reactive strategies)

---

---

What will make the behaviour worse?

---

---

What helps staff to motivate you to stop the behaviours happening? (how do you like to be supported?)

---

---

How do you like staff to support after any behaviour? (post incident support)

---

---



# SAFEGUARDING RISKS

Are there any risks associated with the following?

Vulnerability - risks associated with being subjected to potentially abusive situations, stranger danger etc

---

---

---

---

---

---

---

---

Awareness of dangerous situations - risk associated with being unaware of dangerous situations e.g. road safety, or using equipment)

---

---

---

---

Interactions with other learners - risks associated with interactions with other learners, sexual boundaries, online interactions, being a trigger for others

---

---

---

---

Abscending - risks associated with absconding from different environments

---

---

---

---

Are there any current or historic safeguarding concerns we need to be aware of?

---

---

---

---

If you do not want to document any of these concerns would you like a phone call discussion with a member of the Safeguarding team?

---

---

---

---

# COMMUNICATION

Are you currently seeing a Speech and Language Therapist?

Yes

No

Is Speech and Language Therapy (SLT) named in your EHC Plan?

Yes

No

Have you got an individual communication plan?

Yes

No

If **yes**, please ensure you enclose a copy of this.

What are you currently seeing a Speech and Language Therapist for? (e.g. speech, using signing)

  

Do you enjoy communicating and spending time with others, or do you find this difficult?

  

Do you have difficulties understanding: (please tick all those that apply)

Spoken Language

What is happening around you

Please give any details:

  

Do any of the following things help you to understand: (please tick all that apply)

Objects

Photos

Pictures

Symbols

Signing

Single Words

Short Sentences

Please give any details:

  

How do you express yourself or get your message across?

Body Language

Facial Expression

Vocalisation

Single Words

Short Sentences

Fuller Sentences

Pictures/Photos

Symbols

Objects

Communication Aid

Speaking Switches

Speaking Buttons

# COMMUNICATION

If you use a communication aid, please provide the following details:  
(If you do not have a Communication Aid, please feel free to leave this section blank)

Communication Equipment Details	Funded/ Owned by	Age	Warranty/ Insurance details

\* We need this information in case of requesting additional equipment from the Local Authority

How do you access your Communication Aid?

- Eye Gaze
- Switch (Head/foot)
- Head Pointing
- Direct Access (touch)

Is this effective?

- Yes
- No

If no, why not?

How do you communicate your basic needs or wants? (e.g Yes/No, I want, help me, go away etc)

How do you tell us when you are feeling thirsty/hungry/tired/happy/angry/in pain etc?

# ASSISTIVE TECHNOLOGY

How do you access computers?

- Switch
- Hands
- Eye Gaze
- Fingers (even one at a time)

What equipment do you use?

- Standard keyboard
- Rollerball Mouse
- Big Keys Board
- Joy Stick Mouse
- On Screen Keyboard
- Standard Mouse

Other

Do you use any specialist software?

- Grid 2 or 3
- Dolphin
- Clicker
- Windows accessibility features e.g magnifier
- Dragon (dictation)

Other

# EATING & DRINKING - MEAL TIME SUPPORT

Do you have any special dietary needs (e.g. vegetarian, halal, diabetic, soft, liquidised, thickened etc)

Yes

No

If yes, please provide details:

Do you have or have you ever had any problems with chewing and swallowing?

Yes

No

If yes, please provide details:

Do you have any specific likes or dislikes with eating or drinking? Please give details.

Do you require any changes to ordinary food textures and fluids?

Pureed

Mashed down

Chopped up

With Gravy

Any other details?

Do you require any specific utensils for eating and drinking? Please give details. (e.g. special cups, size of cutlery used etc)

Please give a brief description of how you like carers to support you with eating and drinking. (e.g whether they should be at your right or left side, the pace at which you like to be given food, whether you like a drink between mouthfuls of food etc)

What is the best position for you to be in when eating and drinking? (e.g. in a manual wheelchair with head rest on, facing away from distraction in the room etc)



# OCCUPATIONAL THERAPY

Please complete all questions in this section, even if you haven't had previous Occupational Therapy input.

Please tick here if Occupational Therapy is named in your EHC Plan.

Do you currently have, or have you previously received Occupational Therapy Support?

Yes  No

If yes, what for? Please provide contact details for your Occupational Therapist:

## Equipment

Do you require specialist classroom seating?  Yes  No

Do you require any adapted toileting equipment?  Yes  No

If you answered yes to either of the previous questions, please provide details:

Does this equipment belong to you or your current placement?

Do you currently use any other adapted equipment? Please detail below:

## Sensory

Do you have any sensory processing difficulties that may affect your learning? (e.g. not liking/needing lots of touch, movement, noise, etc?)  Yes  No

If yes, please provide details below and complete the **Sensory Choice Checklist**.

Do you require any sensory equipment (e.g. ear defenders, fidget items etc.)?  Yes  No

If yes, please provide details below.

Do you have any existing sensory strategies (e.g. movement breaks, prompt cards, deep pressure etc.)?  Yes  No

If yes, please provide details below.

# OCCUPATIONAL THERAPY continued

## SENSORY CHOICES CHECKLIST

Below are some questions related to each of the body's senses - please answer these and give as much detail as you are able.

There are also some activities listed that many people use daily to keep themselves **calm** or **alert**.

Please mark anything you like with a ✓ and anything you dislike with an X. Then mark the items you find calming with a C.

### TASTE

- |                                                                                            |                              |                             |
|--------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| Could you be described as a 'picky eater'?                                                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you chew or put inedible items in your mouth?                                           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you dislike the feel of things in your mouth?<br>e.g toothbrush, certain textured food. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

### Further details/comments:

### Activities:

- |                                                   |                                                           |
|---------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Drinking through a straw | <input type="checkbox"/> Drinking through a sports bottle |
| <input type="checkbox"/> Sucking inside of cheeks | <input type="checkbox"/> Sucking/licking/biting lips      |
| <input type="checkbox"/> Grinding teeth           | <input type="checkbox"/> Clenching jaw                    |
| <input type="checkbox"/> Crunching/sucking ice    | <input type="checkbox"/> Crunching crispy foods           |
| <input type="checkbox"/> Chewing gum              | <input type="checkbox"/> Chewing a toothpick              |
| <input type="checkbox"/> Chewing a chewy sweet    | <input type="checkbox"/> Chewing pen/pencil               |
| <input type="checkbox"/> Chewing clothing         | <input type="checkbox"/> Biting nails/hair                |
| <input type="checkbox"/> Blowing bubbles          | <input type="checkbox"/> Whistling                        |
| <input type="checkbox"/> Sucking on a lollypop    |                                                           |

# OCCUPATIONAL THERAPY continued

## SMELL

Do every day smells affect you?  
e.g. petrol smells, food smells.

Yes

No

Do you smell objects/others?

Yes

No

### Further details/comments:

---

---

---

---

### Activities:

Lavender

Aromatherapy

Smelly pens/stickers

Animals

Grass

Strong food smells  
(e.g. curry, fried food)

Sweet / citrus food smells

Perfume

## MOVEMENT

Do you experience motion sickness?

Yes

No

Do you seek out movement?  
e.g. can't sit still, fidgets, rocks, paces.

Yes

No

### Further details/comments:

---

---

---

---

### Activities:

Doodle whilst listening

Rocking body

Sitting in a rocking chair

Jumping/bouncing

Dancing

Pacing

Jiggling leg

Tapping toe, heel or foot

Swaying body side to side

Sitting on an exercise ball

# OCCUPATIONAL THERAPY continued

## TOUCH

Do you regularly touch people and objects?

Yes

No

Do you dislike being touched?

Yes

No

### Further details/comments:

---

---

---

### Activities:

Twiddling hair

Fiddling with objects (e.g. pen)

Being tickled

Having a massage

Having hair washed

Touching fluffy/velvety fabric

Stroking an animal

Tight fitted clothing

Playing in a sand pit

Water play

Picking at nails/skin

Pulling at clothes

Walking bare foot

Rubbing skin/clothing gently

Drumming fingers or pencil

## BODY AWARENESS

Do you bump into stationary objects?  
e.g walls, doors, lampposts.

Yes

No

Do you seek out activities that involve deep pressure?

Yes

No

Do you walk with heavy steps?

Yes

No

Are you aware of when you are in pain?

Yes

No

Do you know when you are too hot or cold?

Yes

No

### Further details/comments:

---

---

---

### Activities:

Yoga

Using weighted equipment

Walking along balance beams

Walking along stepping stones

Throwing and catching a ball

Kicking a ball

Hop scotch

Boccia

# OCCUPATIONAL THERAPY continued

## SIGHT

Do you have difficulty adapting to bright light more than others? (e.g. squint, cover eyes in daylight)?

Yes  No

Are you easily distracted by watching objects or people move around a room?

Yes  No

Do you seek visual stimuli, e.g. looking at lava lamp, fibre optic lights, dim lighting in dark spaces etc?

Yes  No

### Further details/comments:

## HEARING/NOISE

Do you respond emotionally/aggressively to unexpected or loud noises?

Yes  No

Are you overly affected by background noise?

Yes  No

### Further details/comments:

### Activities:

- |                                                                |                                                                                        |
|----------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Make noise for noise sake             | <input type="checkbox"/> Noise making items                                            |
| <input type="checkbox"/> Wearing headphones to listen to music | <input type="checkbox"/> Hearing thunder                                               |
| <input type="checkbox"/> Time in a quiet space                 | <input type="checkbox"/> Wearing headphones/ear defenders/ear plugs to block out noise |
| <input type="checkbox"/> Covering ears with hands              | <input type="checkbox"/> Listening to music                                            |
| <input type="checkbox"/> Hearing alarm                         |                                                                                        |

# OCCUPATIONAL THERAPY continued

## Fine Motor

Do you have any difficulties related to your fine motor skills?

Yes

No

If yes, please provide details:

- |                                        |                                                                         |                                  |                                    |
|----------------------------------------|-------------------------------------------------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Zips          | <input type="checkbox"/> Handwriting                                    | <input type="checkbox"/> Buttons | <input type="checkbox"/> Shoelaces |
| <input type="checkbox"/> Using cutlery | <input type="checkbox"/> Other Classroom activities (including cooking) |                                  |                                    |

Do you have any adapted equipment/garments to help you to complete everyday activities (e.g. adapted cutlery, writing slope, pen grips, Velcro shoes etc.)?

## Travel Training

Do you have any previous experience of Travel Training?

Yes

No

Do you feel that you would be able to travel independently in the near future?

Yes

No

Are there any risks or concerns about accessing the community?

Yes

No

Do you have any difficulties with the following skills:

- |                  |                              |                             |                 |                              |                             |
|------------------|------------------------------|-----------------------------|-----------------|------------------------------|-----------------------------|
| Road safety      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stranger danger | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Money management | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Time management | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Problem solving  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                 |                              |                             |

If answered yes to any of these questions, please provide further details:

## Residential Applicants Only

Do you require any equipment to support with activities of daily living (e.g. shower chair, sleep system etc)?

Yes

No

If yes please provide details, including if you will be bringing the equipment with you to college:

Do you require support with activities of daily living (e.g. brushing teeth, doing laundry, cooking a meal etc)?

Yes

No

Please detail any areas you would like to work on:

# PHYSIOTHERAPY

Do you have physiotherapy named in your EHC Plan?

Yes

No

If you are currently seeing a Physiotherapist please provide their contact details:

  

How do you usually get around?

  

Do you need assistance to get around? (e.g pushing of wheelchair, supervision when walking/driving)

Yes

No

If yes, please provide details:

  

Current physiotherapy goals or things to work towards:

  

## Equipment

Do you use any equipment to help you get around other than a wheelchair?

Orthotics

Stick

Standing Frame

Trike

Walking Frame

If **yes** to any of the above, or if you use any other equipment not listed, please detail below, including if you will be bringing any of this equipment with you to college.

  

Would you be interested in extra physiotherapy sessions during College holiday time?

Yes

No

If relevant, would you like your orthotics needs to be reviewed at Portland by the local NHS orthotics team?

Yes

No

# MOBILITY

How do you transfer from the chair or bed? Please provide details.

---

---

Do you need any equipment or assistance to transfer?

Yes       No

If yes, please provide details:

---

---

# PAIN

If you have pain on a regular basis, please supply us with the following information:

Where is it?

---

How often?

---

How would you describe it?

---

How do you relieve your pain?

---

On the scale below (0 being no pain, and 5 being pain that makes you cry) please mark your pain:

At its best:                                      0                                      1                                      2                                      3                                      4                                      5

At its worst:                                      0                                      1                                      2                                      3                                      4                                      5

Any comments:

---

---

---

---



# MEDICAL HISTORY

Do you have a history of any of the following?

Please tick all boxes that are relevant and provide details where possible.

Epilepsy

If so, please complete the following:

How often do you have a seizure?

How does a seizure present?

How long do the seizures last?

Do you recognise any triggers?  Yes  No

What intervention do you require?

Diabetes (Insulin)

Diabetes (Non insulin)

Heart Problems

Mental Health Problems

Asthma

High Blood Pressure

Eating Disorder

Breathing Difficulties (e.g tracheotomy/oxygen/restriction/repeated chest infections)

Others (e.g. botox, spinal rods, tendon releases, hip displacements etc)

Please provide full details of any of the above, plus any other relevant medical history:

Multiple horizontal text input fields for providing details of medical history.

Do you have any continence needs?  Yes  No

# MEDICAL INFORMATION

Medication Prescribed	How is this taken? (tick all that apply)		
	Orally	Rectally	Peg-fed
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Please ensure that all medication provided is closed, in the correct packaging, ensuring all details are clearly labelled with the recipient's name.

We cannot administer medication if it is not in the correct packaging and labelled correctly.

Do you understand why you are taking this medication?  Yes  No

Do you self-medicate at the moment?  Yes  No

Do you have any PRN or Emergency medication?  Yes  No

If yes, please provide details:

Allergies or Drug Sensitivity (e.g foods, pollens, animals, latex etc)

1
2
3
4
5

# HEARING AND VISION

Do you have any hearing problems?

 Yes No

If so, do you have a hearing aid?

 Yes No

If yes to either question, please provide details, including when the battery was last checked:

  

Do you wear glasses?

 Yes No

If so, when do you wear them?

Do you have any other visual difficulties?

 Yes No

If yes, please provide details:

# SLEEPING, DRESSING AND UNDESSING

Please do not complete this section if you are applying for a day placement.

Do you have a sleeping routine?

 Yes No

Please provide details:

  

Do you like to be in a certain position to help you sleep?

 Yes No

Please provide details:

  

Do you have any special equipment?

 Yes No

Please provide details:

  

Who owns this equipment?

Are you able to use a call alarm system?

 Yes No

What do you use at home? Please provide details:

  

Are you able to direct your care needs?

 Yes No

Are you able to fully dress and undress yourself?

 Yes No

Are you able to make appropriate choices about clothing?

 Yes No

If you need assistance, are you able to direct your carers?

 Yes No

How many carers are required to help you dress?

## Please ensure you complete this page, only if you are applying for a residential place or are considering some Portland Freedom respite.

Please ensure that you enclose a copy of your Community Care Assessment, Care & Support Assessment, or CORE Assessment with this application. Failure to enclose this information will result in a delay in the application process.

### GP Contact

You have the option to register with our local GP, please indicate your preference:  Yes  No

If yes, a member from our nursing team will contact you to complete a registration form.

If no, please complete details below of your current GP practice:

Doctors Name:

Address:

Telephone No:

Please Note: In the case of a medical emergency, Portland College reserves the right to take decisions that would involve contacting our Local GP/emergency services due to our duty of care for all citizens/learners.

Has there been a Power of Attorney applied for on behalf of the individual named on the application form?

Yes  No

If yes, please enclose the original documentation.

# EQUAL OPPORTUNITIES

## For monitoring purposes only

I describe my ethnic background as: (please tick relevant box)

### White

- |                                                                        |                                                     |
|------------------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> English/Welsh/Scottish/Northern Irish/British | <input type="checkbox"/> Irish                      |
| <input type="checkbox"/> Gypsy or Irish Traveller                      | <input type="checkbox"/> Any Other White background |

### Mixed/Multiple Ethnic Group

- |                                                    |                                                                     |
|----------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> White and Black Caribbean | <input type="checkbox"/> White and Black African                    |
| <input type="checkbox"/> White and Asian           | <input type="checkbox"/> Any Other Mixed/Multiple Ethnic background |

### Asian/Asian British

- |                                  |                                                     |                                      |
|----------------------------------|-----------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Indian  | <input type="checkbox"/> Pakistani                  | <input type="checkbox"/> Bangladeshi |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Any Other Asian background |                                      |

### Black/African/Caribbean/Black British

- |                                                                        |                                    |
|------------------------------------------------------------------------|------------------------------------|
| <input type="checkbox"/> African                                       | <input type="checkbox"/> Caribbean |
| <input type="checkbox"/> Any Other Black/African/ Caribbean background |                                    |

### Other Ethnic Group

- |                               |                                                 |
|-------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Arab | <input type="checkbox"/> Any Other Ethnic Group |
|-------------------------------|-------------------------------------------------|

### Age group:

- |                                       |                                |                                |                                |                                |                              |                                            |
|---------------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|------------------------------|--------------------------------------------|
| <input type="checkbox"/> 25 and under | <input type="checkbox"/> 26-34 | <input type="checkbox"/> 35-44 | <input type="checkbox"/> 45-54 | <input type="checkbox"/> 55-64 | <input type="checkbox"/> 65+ | <input type="checkbox"/> Prefer not to say |
|---------------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|------------------------------|--------------------------------------------|

The capture of this data is a requirement of both Ofsted and CQC, and as a college we have to provide data of our learner cohort. The college Privacy Policy can be access on our website: [www.portland.ac.uk](http://www.portland.ac.uk)  
A Learner Privacy Policy is available on request from the college's Data Manager.

# EQUAL OPPORTUNITIES continued

## For monitoring purposes only

How would you define your gender:

<input type="checkbox"/> Man	<input type="checkbox"/> Woman	<input type="checkbox"/> Prefer not to say
<input type="checkbox"/> Other (Please specify)		

Marital status:

<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Civil Partnership	<input type="checkbox"/> Separated
<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced	<input type="checkbox"/> Prefer not to say	

Sexual orientation

<input type="checkbox"/> Lesbian or gay	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Straight	<input type="checkbox"/> Prefer not to say
<input type="checkbox"/> Applicant does not have the capacity			
<input type="checkbox"/> Other (Please specify)			

Religion or belief

<input type="checkbox"/> Christian	<input type="checkbox"/> Muslim	<input type="checkbox"/> Buddhist	<input type="checkbox"/> Sikh
<input type="checkbox"/> Hindu	<input type="checkbox"/> Jewish	<input type="checkbox"/> None	<input type="checkbox"/> Prefer not to say
<input type="checkbox"/> Other (Please specify)			

The capture of this data is a requirement of both Ofsted and CQC, and as a college we have to provide data of our learner cohort. The college Privacy Policy can be access on our website: [www.portland.ac.uk](http://www.portland.ac.uk)  
A Learner Privacy Policy is available on request from the college's Data Manager.