

OVER 60s FREE SWIMMING APPLICATION FORM

Customer Information																			
First Name:	Surname:	Male		Female		Date of Birth													
Address:		Home Telephone Number:																	
		Mobile Phone Number:*																	
Postcode:		Email Address:																	
<p>Ethnic Origin:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Chinese <input type="checkbox"/></td> <td style="width: 33%;">Other Asian <input type="checkbox"/></td> <td style="width: 33%;">Pakistani <input type="checkbox"/></td> </tr> <tr> <td>Bangladeshi <input type="checkbox"/></td> <td>Indian <input type="checkbox"/></td> <td>Black Caribbean <input type="checkbox"/></td> </tr> <tr> <td>Black African <input type="checkbox"/></td> <td>Black Other <input type="checkbox"/></td> <td>Mixed Ethnicity <input type="checkbox"/></td> </tr> <tr> <td>White <input type="checkbox"/></td> <td colspan="2">Other (Please specify) _____</td> </tr> </table>								Chinese <input type="checkbox"/>	Other Asian <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Indian <input type="checkbox"/>	Black Caribbean <input type="checkbox"/>	Black African <input type="checkbox"/>	Black Other <input type="checkbox"/>	Mixed Ethnicity <input type="checkbox"/>	White <input type="checkbox"/>	Other (Please specify) _____	
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White <input type="checkbox"/>	Other (Please specify) _____																		
<p>Disability:</p> <p>Do you consider yourself to have a disability? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes, please specify:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Mobility/Physical <input type="checkbox"/></td> <td style="width: 33%;">Hearing <input type="checkbox"/></td> <td style="width: 33%;"></td> </tr> <tr> <td>Seeing <input type="checkbox"/></td> <td>Mental Health <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Learning <input type="checkbox"/></td> <td colspan="2">Other (Please specify) _____</td> </tr> </table>								Mobility/Physical <input type="checkbox"/>	Hearing <input type="checkbox"/>		Seeing <input type="checkbox"/>	Mental Health <input type="checkbox"/>		Learning <input type="checkbox"/>	Other (Please specify) _____				
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Signed: (Applicant)		Signed:			Date:														