

BOOKING CUSTOMER APPLICATION FORM

Customer Information																			
First Name:	Surname:	Male		Female		Date of Birth													
Address:		Home Telephone Number:																	
		Mobile Phone Number:*																	
Postcode:		* Under 16s must provide written consent from a parent/guardian																	
		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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<p>Data Protection:</p> <p>Your details may be used and disclosed to Aylesbury Community Trust and/or other organisations, which may be of interest to you, or for market research. If you would prefer not to receive this marketing or other information you may write to us at any time or put a tick in this box <input type="checkbox"/></p> <p>If you have provided your email address and would like to receive marketing and/or other information by this method from Aylesbury Community Trust and/or other organisations please tick this box <input type="checkbox"/></p> <p>If you have provided your mobile number and would like to receive marketing and/or other information by this method from Aylesbury Community Trust and/or other organisations please tick this box <input type="checkbox"/></p>																			
<p>I have read and understood the Booking and Cancellation Policy:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Signed: (Applicant)</td> <td style="width: 33%;">Signed: (Parent/Guardian if Applicable)</td> <td style="width: 33%;">Date:</td> </tr> </table>								Signed: (Applicant)	Signed: (Parent/Guardian if Applicable)	Date:									
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