

Equality Monitoring Form

ARB is committed to promoting equality and diversity in every aspect of our work. We aim to ensure that our services and policies are free from any form of discrimination and are fair to all, irrespective of race, age, gender, disability, sexual orientation, gender reassignment, religion or belief.



Age	<input type="checkbox"/> Under 18	<input type="checkbox"/> 18-35	<input type="checkbox"/> 35-50	<input type="checkbox"/> 51-65	<input type="checkbox"/> Over 65	<input type="checkbox"/> Prefer not to say
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Prefer not to say			

I would describe my ethnic origin as:		
Asian or Asian British <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Any other Asian background	Mixed <input type="checkbox"/> White & Asian <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> Any other mixed background	Other Ethnic Group <input type="checkbox"/> Chinese <input type="checkbox"/> Any other ethnic group _____ <input type="checkbox"/> Prefer not to say
Black or Black British <input type="checkbox"/> African <input type="checkbox"/> Caribbean <input type="checkbox"/> Any other Black background	White <input type="checkbox"/> British (Scottish/English/Welsh) <input type="checkbox"/> Irish <input type="checkbox"/> Any other White background	

Please select the option which best describes your sexuality	
<input type="checkbox"/> Lesbian <input type="checkbox"/> Gay <input type="checkbox"/> Bisexual	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Prefer not to say

Please indicate your religion or belief		
<input type="checkbox"/> Atheist <input type="checkbox"/> Buddhist <input type="checkbox"/> Christian (all Christian denominations)	<input type="checkbox"/> Muslim <input type="checkbox"/> Sikh <input type="checkbox"/> Hindu	<input type="checkbox"/> Jewish <input type="checkbox"/> Other _____ <input type="checkbox"/> Non-religious <input type="checkbox"/> Prefer not to say

Do you consider yourself to have a disability? By disability, we mean any impairment that has a substantial and long-term effect on your ability to carry out normal day-to-day duties	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to say
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For office use only	Number.
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