

# HILLINGDON HOSPITAL TRUST LIBRARY – ENROLMENT FORM

Please complete this form in block capitals

ID Shown (Library Use)

Title: \_\_\_\_\_ Forename(s): \_\_\_\_\_ Surname: \_\_\_\_\_

## Employer / Place of Study (Please tick all that apply)

Hillingdon Hospital NHS Trust	<input type="checkbox"/>	Local GP Practice	<input type="checkbox"/>
Hillingdon Primary Care Trust	<input type="checkbox"/>	Imperial College	<input type="checkbox"/>
Hillingdon Health Authority	<input type="checkbox"/>	Buckinghamshire Chilterns Univ. College	<input type="checkbox"/>
London Borough of Hillingdon	<input type="checkbox"/>	Brunel University	<input type="checkbox"/>
Other (Please Specify): _____			

## Post (Please select the most appropriate)

Consultant	<input type="checkbox"/>	Ward Manager	<input type="checkbox"/>	Physiotherapist	<input type="checkbox"/>
Associate Specialist	<input type="checkbox"/>	Sister	<input type="checkbox"/>	Occupational Therapist	<input type="checkbox"/>
Specialist Registrar	<input type="checkbox"/>	Clinical Nurse Specialist	<input type="checkbox"/>	Dietitian / Nutritionist	<input type="checkbox"/>
SHO	<input type="checkbox"/>	Practice Nurse	<input type="checkbox"/>	Speech Therapist	<input type="checkbox"/>
HO	<input type="checkbox"/>	Midwife	<input type="checkbox"/>	Audiologist	<input type="checkbox"/>
Staff Grade (doctor)	<input type="checkbox"/>	Staff Nurse	<input type="checkbox"/>	Podiatrist / Chiropodist	<input type="checkbox"/>
Clinical Assistant	<input type="checkbox"/>	CPN	<input type="checkbox"/>	Pharmacist	<input type="checkbox"/>
Clinical Attachment	<input type="checkbox"/>	RMN	<input type="checkbox"/>	Radiographer	<input type="checkbox"/>
GP	<input type="checkbox"/>	Nurse Tutor / Lecturer	<input type="checkbox"/>	OPD / OPA	<input type="checkbox"/>
GP Trainee	<input type="checkbox"/>	Nurse Practitioner	<input type="checkbox"/>	Scientist / MLSO	<input type="checkbox"/>
Dentist	<input type="checkbox"/>	District Nurse	<input type="checkbox"/>	Clinical Psychologist	<input type="checkbox"/>
Medical Student	<input type="checkbox"/>	Health Visitor	<input type="checkbox"/>	Clinical Psychotherapist	<input type="checkbox"/>
Researcher	<input type="checkbox"/>	Health Care Assistant	<input type="checkbox"/>	Social Worker	<input type="checkbox"/>
Manager (non-clinical)	<input type="checkbox"/>	Student Midwife	<input type="checkbox"/>	Student AHP	<input type="checkbox"/>
Admin / Clerical	<input type="checkbox"/>	Student Nurse	<input type="checkbox"/>	BANK staff	<input type="checkbox"/>
Other (Please specify): _____					

Dept. (& Location): \_\_\_\_\_ Tel / Ext / Bleep: \_\_\_\_\_

Work Address (if not on site): \_\_\_\_\_

Permanent / Leaving Date (Specify): \_\_\_\_\_ Full Time / Part Time / Locum / Observing / BANK

Home Address (if this is not a permanent address i.e. student accommodation, please give a permanent address below):

\_\_\_\_\_

\_\_\_\_\_ Telephone No. \_\_\_\_\_

Permanent Home Address (if not given above):

\_\_\_\_\_

\_\_\_\_\_ Telephone No. \_\_\_\_\_

Email Address: \_\_\_\_\_

*I agree to observe library regulations and agree not to disclose any codes or passwords issued by the Library to any third party. I understand that the information submitted on this form may be used by library staff in connection with the provision and promotion of library services. I understand that this information is provided solely for use by Hillingdon Hospital Trust Library and will not be made available to any other staff, department or outside organisation.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_