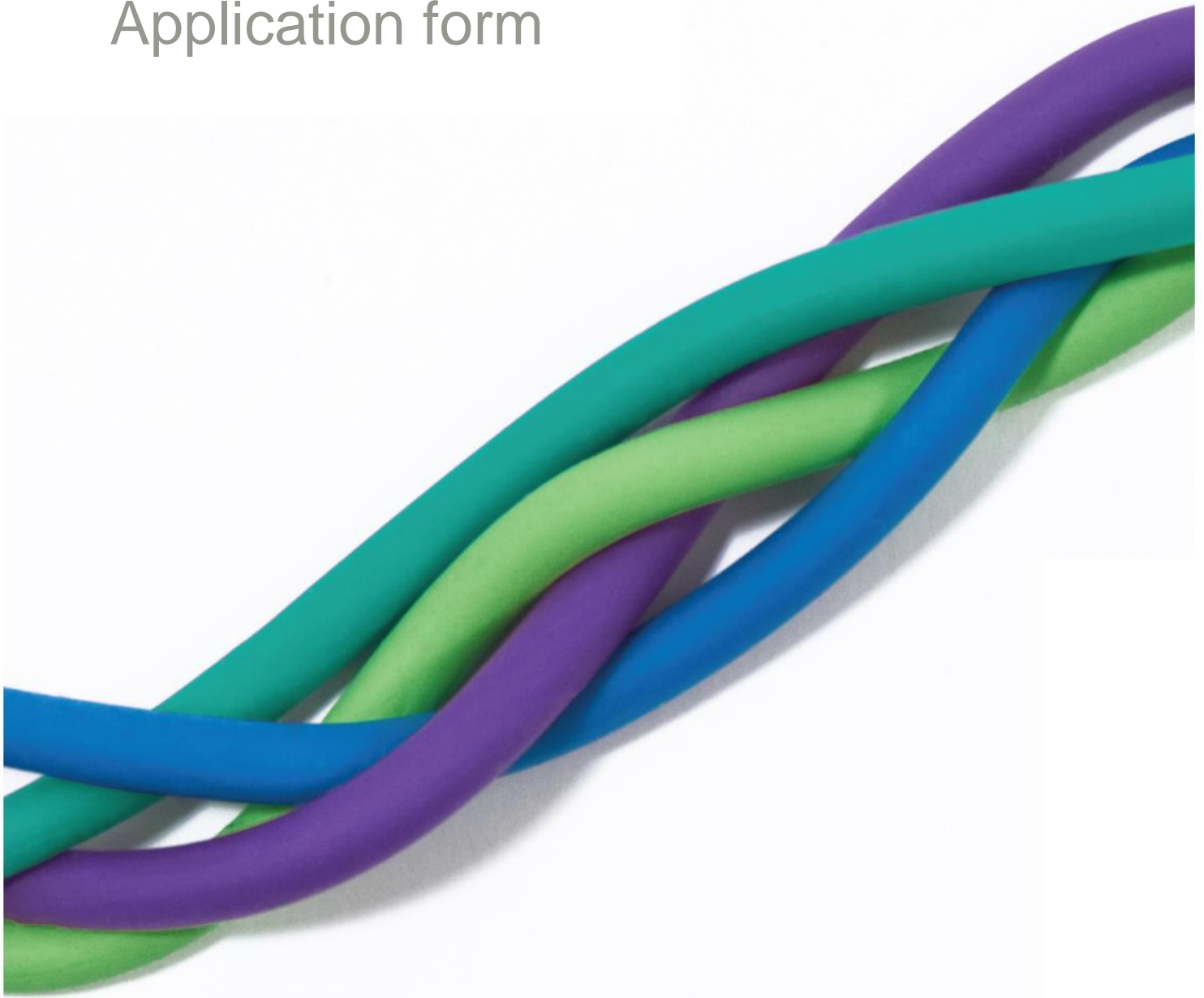


Talent Management Development Programme

Application form



Putting leadership at the
heart of quality care

Section 1: Contact Details

Contact details of applicant			
Name (and title)			
Profession			
Job title		Band	
Organisation name			
Contact address			
Telephone			
Email			
PA email			

Section 2: Talent Management Knowledge & Experience

Will you be taking a lead role in your organisation for the implementation of Talent Management? <small>(please tick relevant box)</small>			
Yes		No	
Are you a member of the KSS Talent Management network? <small>(please tick relevant box)</small>			
Yes		No	
What is your current level of Talent Management knowledge and experience?			
Please briefly describe what is already in place to identify and develop talent within your organisation.			



What do you intend to implement or do differently as a result of having participated in the Talent Management Development programme?

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Section 4: Agreement

To be completed by the applicant

I have read, fully understand and commit to:

- Becoming / continuing to be an active member of the KSS Talent Management network
- Promoting the Talent Management agenda in my organisation
- Contributing to the development of a Talent Management strategy in my organisation
- Proactively implementing and sharing my Talent Management knowledge and expertise with colleagues

Name:
Signature:
Date:

Complete the form and return either by email leadership.kss@hee.nhs.uk or post to *NHS KSS Leadership Collaborative, Third Floor, Red Wing, Crawley Hospital, West Green Drive, Crawley, West Sussex, RH11 7D.*



Monitoring Information

This form will be used for monitoring purposes only. NHS KSS Leadership Collaborative recognise and actively promote the benefits of a diverse workforce and are committed to treating all employees with dignity and respect regardless of race, gender, disability, age, sexual orientation, religion or belief.

* Age	<input type="checkbox"/> Under 20 <input type="checkbox"/> 40-49 <input type="checkbox"/> 20-29 <input type="checkbox"/> 50-59 <input type="checkbox"/> 30-39 <input type="checkbox"/> 30-39	
* Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> I do not wish to disclose this	
* 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 Black or Black British <input type="checkbox"/> African <input type="checkbox"/> Caribbean <input type="checkbox"/> Any other Black background	Mixed <input type="checkbox"/> White & Asian <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> Any other mixed background White <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Gypsy or Irish Traveller <input type="checkbox"/> Any other White background	Other Ethnic Group <input type="checkbox"/> Chinese <input type="checkbox"/> Any other ethnic group <input type="checkbox"/> I do not wish to disclose this
* Please select the option which best describes your sexuality		
<input type="checkbox"/> Bisexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Other <input type="checkbox"/> I do not wish to disclose this	
* Please indicate your religion or belief		
<input type="checkbox"/> Buddhist <input type="checkbox"/> Christian <input type="checkbox"/> Muslim	<input type="checkbox"/> Sikh <input type="checkbox"/> Jewish <input type="checkbox"/> Hindu	<input type="checkbox"/> Other <input type="checkbox"/> No religion <input type="checkbox"/> I do not wish to disclose this
* Do you consider yourself to be a disabled person as defined by the Equality Act 2010?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not wish to disclose this information	
If you answered Yes, please state the type or types of impairment which applies to you. If you are disabled but none of the listed categories apply, please mark 'other'.		
<input type="checkbox"/> Physical Impairment <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Mental Health Problem	<input type="checkbox"/> Learning Disability/Difficulty <input type="checkbox"/> Long-standing illness <input type="checkbox"/> Other	

