



**LANCASTER TRAINING
SERVICES LTD.**

Applicant's FULL name:

DATE of birth:

DATE of application:

**APPRENTICESHIP
APPLICATION
FORM**



Please return the completed form to:

Lancaster Training Services Ltd

The Training Centre

5 Penrod Way

Heysham

Morecambe

Lancashire LA3 2UZ

Tel: 01524 858326

Fax: 01524 858740

Please complete this form in **BLACK INK** using **BLOCK CAPITALS**

1 Apprenticeships learning provider

Name of learning provider	Lancaster Training Services Ltd						
How did you hear about us? Please tick the appropriate box	Connexions		Careers Convention		Employer		School
	Internet		Advertisement		Jobcentre Plus		
Other - please state							

2 Type of job/training

What kind of job/training do you want?	1 st choice:
	2 nd choice:

3 Personal details

Title	Mr		Mrs		Miss		Ms		Are you	Male/Female	
Last name											
First name(s)											
Address											
	Postcode:										
Telephone no.					Mobile no.						
E-mail address					Date of birth				Age		
National Insurance no.											
Unique Learner no											

How many years have you been a resident in England?	YEARS	MONTHS
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To help us see how our equal opportunities policy is working, please tell us to which of these groups you belong:

White	British	<input type="checkbox"/>	Irish	<input type="checkbox"/>	Any other white background	<input type="checkbox"/>
Mixed	White & Black Caribbean	<input type="checkbox"/>	White & Black African	<input type="checkbox"/>	White & Asian	<input type="checkbox"/>
Asian/Asian British	Indian	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>
Black/ Black British	Caribbean	<input type="checkbox"/>	African	<input type="checkbox"/>	Any other mixed background	<input type="checkbox"/>
Chinese or Other Ethnic Group	Chinese	<input type="checkbox"/>	Any Other	<input type="checkbox"/>	Any other Asian background	<input type="checkbox"/>
					Any other black background	<input type="checkbox"/>

4 Parent (s) / guardian (s)

Complete this **only** if **different** from your own address

Last name										
First name (s)										
Address										
	Postcode:									
Telephone no										

5 Education

Name and address of most recent school					
	From (year)		Date leaving/left school		

Name and address of college or sixth form attended					
	From (year)		Date leaving/left		

Name and address of current full-time employer if applicable			

6 Qualifications being studied or already taken

Subject	GCSE, A-level, GNVQ, NVQ or other type of qualification	Grades		Year exam taken
		Expected	Achieved	

7 Previous Training

Ignore this section if you have just left school or college

If you have previously done any work-based training, including Apprenticeships or NVQ Learning, please give details

Learning provider's name	Type of job/training	From (month/year)	To (month/year)

8 Previous work experience/employment

Please give details of previous school/college-based work experience, and full or part-time employment other than Apprenticeships or NVQ Learning.

Company name and address	Type of work experience/employment	From (month/year)	To (month/year)

9 Additional Information

Please use this space to give additional information to support your application, e.g. activities in and out of school, other relevant achievements such as positions of responsibility, and an indication as to why you have chosen this particular occupation. (continue on a separate sheet of paper if necessary)

10 Health Record

The aim of this section is to ensure you are able to access your preferred choice of employment unless the risks to your safety and health cannot be controlled. We will make every effort to help you achieve your goals.

To help Lancaster Training Services to place you in an appropriate job or training placement and to help you with any additional support you may need, please provide the following information. If you need help to complete this section please ask.

Do you have/experience any of the following?

Epilepsy	<input type="checkbox"/>	Skin complaints	<input type="checkbox"/>	Heart condition	<input type="checkbox"/>
Asthma/bronchitis	<input type="checkbox"/>	Hearing impairment	<input type="checkbox"/>	Visual impairment	<input type="checkbox"/>
Colour blindness	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Dyslexia	<input type="checkbox"/>
Arthritis/rheumatism	<input type="checkbox"/>	Physical injuries to back, legs or arms	<input type="checkbox"/>		
Learning difficulties	<input type="checkbox"/>	Other (if yes please specify below)	<input type="checkbox"/>		

Data Protection Act 1998: The information contained within this form may be shared with other learning providers, potential employers and the national Connexions Service.

Please tick this box if you do **NOT** want your details to be passed on

When you have completed as much of this form as you can, please sign in this box.

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Date

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