



OLP EVENT PRODUCTION - PARTICIPANT REFERRAL FORM

(FOR COMPLETION BY INDIVIDUAL OR REFERRING ORGANISATION AND DELIVERY HUB PARTNER OR SUB-CONTRACTOR)

Eligibility

The participant must be able to tick all four boxes:

- Aged 16+
- Not in any education or training
- Unemployed (not working)
- Eligible to work in the EU

Title			
Surname			
First name			
Date of birth		NI No.	
Home address			
Town		Postcode	

Tel no. **Mobile**

Email

Gender **Male** **Female**

Disability/health condition **Yes** **No** **Prefer not to say**

Lone parent **Yes** **No**

Support needs – please outline any support needs (i.e. 1-1 support worker, interpreter, level access, transport, childcare, dietary requirements, reading, writing etc)

I would like help with:

- Building confidence/self-esteem
- Developing motivation/concentration/attendance
- Planning for training/work
- Information/Advice/Guidance
- Addressing/overcoming barriers to further learning, training or job searching due to learning difficulties/disability/health issues
- Other:.....

Qualifications: held prior to the start of this programme: (please tick)

Qualification level			
None	<input type="checkbox"/>	A-Level or equivalent (level 3)	<input type="checkbox"/>
Entry Level or below	<input type="checkbox"/>	Degree or equivalent (level 4)	<input type="checkbox"/>
GCSE (D-F) or equivalent (level 1)	<input type="checkbox"/>	MA or higher or equivalent (level 5)	<input type="checkbox"/>
GCSE (A-C) or equivalent (level 2)	<input type="checkbox"/>	Not known	<input type="checkbox"/>

Your current situation: Please tick:

EITHER

I am unemployed and looking for work

▶ If unemployed and looking for work, please give length of unemployment (months):

under 6 6-11 12-23 24-35 over 36

OR

I am not working and NOT looking for work at this time

PARTICIPANT'S DECLARATION

The information I have provided above is correct and can be used by the provider named on this form to register me as a participant on ESF provision.

PARTICIPANT'S SIGNATURE:

..... DATE:.....

If you are making a referral please give details below: :

ORGANISATION	
Contact Name (BLOCK CAPS)	
Position/Job Title	
Contact Tel No.	
Signature	
Date	

RETURN TO:

DELIVERY HUB OFFICE:	
Participant ref no. __ / __ / __	
Name _____ Signature _____	Date _____
COVER Received/checked (name) _____	Date _____