

Interpersonal Skills Questionnaire (ISQ) Application Form

Please complete in BLOCK CAPITALS

| Step 1 Fill in your details | Step 2 Profession | Step 3 Price Guide |
|--------------------------------|--|--------------------------------------|
| Name of applicant: | (Dr/Mr/Mrs/Ms/Miss) | Gender: |
| Date of Birth: | Year of Registration: | Appraisal Date: (if known) |
| Employer: | Health organisation eg: PCT, Trust (if different): | |
| Address: | Post Code: | |
| Direct contact tel no: | E-mail address: | |

We may contact you from time to time to keep you up to date with products and services that we feel may be of interest to you. If you would like us not to retain your e-mail address for this purpose, please tick here

| Step 1 Fill in your details | Step 2 Profession | Step 3 Price Guide |
|---|--|--|
| <p>Please select from A or B below, and tick the option which best suits your occupation.</p> | | |
| <p>A) Primary Care</p> | | |
| <input type="checkbox"/> GP <input type="checkbox"/> Nurse | <input type="checkbox"/> Partner <input type="checkbox"/> Locum <input type="checkbox"/> Registrar <input type="checkbox"/> Nurse <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Salaried doctor <input type="checkbox"/> Prison doctor <input type="checkbox"/> Other: _____ <input type="checkbox"/> OOH doctor <input type="checkbox"/> Military doctor <input type="checkbox"/> Full time <input type="checkbox"/> Part time |
| <p>B) Secondary Care Please select an option from the left hand column and specialty from the right hand columns</p> | | |
| <input type="checkbox"/> Consultant <input type="checkbox"/> SAS <input type="checkbox"/> Specialist Training Registrar <input type="checkbox"/> Foundation Doctor <input type="checkbox"/> Medical Student Other: _____ <input type="checkbox"/> Nurse | <input type="checkbox"/> Accident & Emergency <input type="checkbox"/> Anaesthetics <input type="checkbox"/> Medicine <input type="checkbox"/> Obstetrics & Gynaecology <input type="checkbox"/> Paediatrics <input type="checkbox"/> Allied Health Professional (details): _____ | <input type="checkbox"/> Pathology <input type="checkbox"/> Mental Health <input type="checkbox"/> Public Health <input type="checkbox"/> Surgery <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Radiology <input type="checkbox"/> Intensive Care |



For more information or guidance on any aspect of the questionnaire, please contact **0845 519 7493** or e-mail **enquiries@cfep.co.uk**

An all-inclusive cost of £66 + VAT per participating clinician

This price includes complete survey pack, feedback report, and supporting materials.

NB: Questionnaires cannot be photocopied. The number of questionnaires sent should be sufficient to provide adequate returns. However, if further questionnaires are needed there will be an additional cost for survey material.

We will send you 40 questionnaires.

We need to make sure that the results we provide for you are statistically valid so please ensure that you **return a minimum of 25** completed questionnaires.

Please note that we may need to contact you for further questionnaires if blank or incomplete forms mean that we do not have enough to ensure statistical validity.

I would like to receive my survey pack on

[date]: _____
(Allow 10 working days for delivery)

You will receive an electronic copy of the report.

You can receive a bound copy for £15 + VAT.

Please tick box

Price calculator

Survey price

Optional extras
Bound report
add £15

Subtotal

Please add VAT

Total

Please tick here if you would like a VAT receipt

I confirm that I have read and accept the terms and conditions of the service provided by CFEP UK Surveys (see www.cfepsurveys.co.uk or contact us for a printed version).

Signed _____ Date _____

Complete this form, post / fax it to us and phone us on 0845 519 7493 with your credit or debit card details.

Alternatively cheques should be made payable to CFEP UK Surveys Ltd and sent to us at;

31, Basepoint Business Centre, Yeoford Way, Marsh Barton, Exeter EX2 8LB



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