



Equality and Diversity Monitoring Form

REASONABLE ADJUSTMENTS

If you need any reasonable adjustments to support you to complete this form, please tell us. For example, if you have a visual impairment, you might need us to provide information in larger text.

IN CONFIDENCE

We ask everyone who applies for a complaint handling review to complete this form. We use the information you give us to help identify trends in complaints about the police. We also use it to monitor and improve our service.

The information that you provide is not seen by anyone involved in the review of your complaint. We treat your information in the strictest confidence. Our privacy notice will give you more information around how we treat your data. No information will be published or used in any way that allows individuals to be identified.

You do not have to fill in this form if you do not want to. You also do not have to answer all the questions. If you choose to fill in this form you will be helping us to track the effectiveness of our policies on Equality and Diversity.

Age Group

16 - 24	<input type="checkbox"/>	25 - 34	<input type="checkbox"/>
35 - 44	<input type="checkbox"/>	45 - 54	<input type="checkbox"/>
55 - 64	<input type="checkbox"/>	65 - 74	<input type="checkbox"/>
Above 74	<input type="checkbox"/>		

Sex/Gender

At birth, were you described as...

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>
Intersex	<input type="checkbox"/>
Don't know	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>



How would you describe your gender?

Woman	<input type="checkbox"/>
Man	<input type="checkbox"/>
Transwoman	<input type="checkbox"/>
Transman	<input type="checkbox"/>
Non-Binary	<input type="checkbox"/>
Don't know	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>
Other	<input type="checkbox"/>

Sexual Orientation

Heterosexual or Straight	<input type="checkbox"/>
Gay	<input type="checkbox"/>
Lesbian	<input type="checkbox"/>
Bisexual	<input type="checkbox"/>
Other sexual orientation (please state)	
Prefer not to say	<input type="checkbox"/>

Ethnicity

White		Asian/Asian Scottish/ Asian British	
Scottish	<input type="checkbox"/>	Indian, Indian Scottish or Indian British	<input type="checkbox"/>
English	<input type="checkbox"/>	Pakistani, Pakistani Scottish or Pakistani British	<input type="checkbox"/>
Welsh	<input type="checkbox"/>	Bangladeshi, Bangladeshi Scottish or Bangladeshi British	<input type="checkbox"/>
Irish	<input type="checkbox"/>	Chinese, Chinese Scottish or Chinese British	<input type="checkbox"/>
British	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>
Gypsy/ Traveller	<input type="checkbox"/>	Other (please state)	
Prefer not to say	<input type="checkbox"/>		
Other Please state)			
African		Mixed/Multiple Ethnic Groups	
African, African Scottish or African British	<input type="checkbox"/>	Any mixed or multiple ethnic groups, please state	<input type="checkbox"/>



Prefer not to say	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>
Other (Please state)		Other (Please state)	
Caribbean or Black	<input type="checkbox"/>		
Caribbean, Caribbean Scottish or Caribbean British	<input type="checkbox"/>		
Other Ethnic Group (Please state)			
Arab, Arab Scottish or Arab British	<input type="checkbox"/>		
<u>Other, please state</u>			

Religion or Belief

None	<input type="checkbox"/>
Church of Scotland	<input type="checkbox"/>
Roman Catholic	<input type="checkbox"/>
Other Christian	<input type="checkbox"/>
Buddhist	<input type="checkbox"/>
Hindu	<input type="checkbox"/>
Jewish	<input type="checkbox"/>
Muslim	<input type="checkbox"/>
Sikh	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>
Other (Please state)	

Disability

Do you have any of the following, which have lasted, or are expected to last, at least 12 months?

Tick all that apply

Deafness or partial hearing loss	<input type="checkbox"/>
Blindness or partial sight loss	<input type="checkbox"/>
Full or partial loss of voice or difficulty speaking (a condition that requires you to use equipment to speak)	<input type="checkbox"/>
Learning disability (a condition that you have had since childhood that affects the way you learn, understand information and communicate)	<input type="checkbox"/>
Learning difficulty (a specific learning condition that affects the way you learn and process information)	<input type="checkbox"/>



Developmental disorder (a condition that you have had since childhood which affects motor, cognitive, social and emotional skills, and speech and language)	<input type="checkbox"/>
Physical disability (a condition that substantially limits one or more basic physical activities such as walking, climbing stairs, lifting or carrying)	<input type="checkbox"/>
Mental health condition (a condition that affects your emotional, physical and mental wellbeing)	<input type="checkbox"/>
Long-term illness, disease or condition (a condition, not listed above, that you may have for life, which may be managed with treatment or medication)	<input type="checkbox"/>
Other condition , please write in:	
No condition	<input type="checkbox"/>

Pregnancy/Maternity

Are you currently pregnant?	<input type="checkbox"/>
Have you been pregnant in the past year?	<input type="checkbox"/>
Are you currently on maternity/paternity/adoption/shared parental leave?	<input type="checkbox"/>
Have you been on maternity/paternity/adoption/shared parental leave in the past year?	<input type="checkbox"/>