AVERICK television

‘My Naked Secret’
Application Form

Thank you for showing an interest in ‘My Naked Secret’

This Discovery series aims to follow patients with a variety of medical and physical conditions. Through our team of leading medical specialists the show will aim to consult, diagnose and treat conditions that have left the patient feeling scared to reveal to friends and family.

If you would like to be considered for any future series of the show, please complete the form below.

The information collected on this application will be kept in the strictest confidence and will not be disclosed to any third party (except the Broadcaster) for any purpose other than for the purposes stated herein.

Your personal information will only be used for the purpose of evaluating whether you would be a suitable contributor to the programme or any other programme produced by Maverick Television Ltd. Your personal information will NOT be used for any marketing, publicity or research purposes.

By completing this form you agree for your personal and sensitive information to be processed lawfully by Maverick for the purposes of the proposed programme. All information will be dealt with according to the Data Protection Act 1998 and all other applicable laws and regulation with respect to Data Protection.

Please note that while we will enlist the help of reputable professionals in their fields, we cannot of course guarantee that if you are ultimately selected that our medical team will be able to solve your medical problems, successfully treat your conditions or that you will be completely happy with any of the treatments that you receive.

GUIDANCE FOR APPLICANTS

- **Whether you get selected or not, you should also get your symptoms looked at by your own GP.**
- **Your application is confidential – your application will only be viewed by production staff and the medical team. Any pictures you send to us will be destroyed as soon as production has ended.**
- **Under 18 applications – you will need parental consent to take part in the programme. Please fill in the relevant box below with your parent/guardian’s contact details.**
- **Please attach photos – to help us diagnose your problem and find a suitable course of treatment, we need to see pictures.**
- **Please enclose/attach (a) A head and shoulders photograph, (b) Photographs of your health concern/symptoms**
- **Please ensure you complete all of the required fields below, including the health questionnaire. The more you tell us, the more we may be able to help you.**
- **Please note, we cannot guarantee that you will receive a consultation.**
- **Before completing your form, please consider whether you will be able to commit to consultations within the next few months.**

- **You can email or post your application to us. Details can be found at the end of the application form.**

PERSONAL DETAILS

NAME	
AGE	
DATE OF BIRTH	
HEIGHT	
WEIGHT	
EMAIL ADDRESS	
CONTACT NUMBERS	MOBILE
	WORK
	HOME
ADDRESS	
OCCUPATION	
PREVIOUS TV EXPERIENCE (if any)	
GP – NAME AND ADDRESS / TELEPHONE	

UNDER 18'S – PLEASE COMPLETE			
DO YOUR PARENTS KNOW ABOUT YOUR CONDITION?	Y / N	**HAVE YOUR PARENTS GIVEN YOU CONSENT TO CONTACT US?**	Y / N

PARENT/GUARDIAN'S CONTACT DETAILS	

YOUR HEALTH COMPLAINT

TELL US ABOUT YOUR HEALTH CONDITION

DESCRIBE THE SYMPTOMS?

- HOW LONG HAVE YOU HAD THE CONDITION? DATES PLEASE
- HOW DOES IT LOOK/FEEL/SMELL?
- DOES ANYONE ELSE IN YOUR FAMILY SUFFER FROM THE SAME CONDITION?

HAVE YOU VISITED A GP / SPECIALISTS?
IF YES –

- WHEN?
- HOW MANY VISITS?
- WHO DID YOU SEE? I.E. GP / REFERRALS TO SPECIALISTS
- PLEASE GIVE DATES
- WHAT WAS THEIR DIAGNOSIS?

IF NO –

- WHY NOT?

WHAT TREATMENTS HAVE YOU TRIED? PLEASE LIST ALL..
WHAT IMPACT HAVE THOSE TREATMENTS HAD? PLEASE GIVE FULL DETAILS.

HOW DOES THE CONDITION AFFECT YOUR LIFE? PLEASE GIVE DETAILS.
(YOUR CONFIDENCE, BEHAVIOUR, HOME LIFE, SCHOOL LIFE, WORK, FRIENDSHIPS, SEX LIFE, RELATIONSHIPS)

ARE YOUR FAMILY, FRIENDS OR PARTNER AWARE OF YOUR CONDITION?
(IF NOT WHY?)

HOW DO YOU CONCEAL YOUR CONDITION? (CLOTHING, REFUSING TO UNDRESS ETC)

ARE THERE ANY DATES WHEN YOU ARE NOT AVAILABLE FROM DEC 2010 – MAY 2011? EG: HOLIDAYS BOOKED?

Do you have any criminal convictions past or pending? All information supplied remains confidential.	Please Tick **Y( ) N ( )** *If yes, please give details with type of conviction/proceeding, including dates.*
Are you involved in any court proceedings at present or awaiting trial or charge in respect of any criminal offence or suspected criminal offence? Please include any marital/child proceedings. All information supplied remains confidential.	Please Tick **Y( ) N ( )** *If yes, please give details with type of proceeding, including dates.*
Where did you see the advert for the show?	
Would you like to be considered for other Maverick Television shows?	Please Tick **Y( ) N ( )**

NB. Please be aware that depending on the diagnosis of your condition there may need to be some time available for recovery from surgery which could impact on work/school commitments. For this reason, there will need to be some degree of flexibility in your availability over the next few months.

Please tick (✓) in the appropriate column and where an answer is 'yes' please provide details.
You may attach an additional sheet where necessary

HAVE YOU EVER HAVE SUFFERED:	**NO**	**YES**	**REMARKS:**
Angina?			
Heart Attack?			
Other health problems?			
High blood pressure?			
Irregular heartbeat?			
Stroke?			
Ankle Swelling?			
Pain in legs on walking?			
Thrombosis (Blood Clots)?			
Other circulation problems?			
Shortness of breath?			
Persistent cough?			
Coughing up blood?			
Asthma?			
Gall Stones			
Recurrent indigestion/heartburn?			
Stomach ulcer?			
Hernia?			
Recurrent diarrhoea/constipation?			
HAVE YOU EVER HAVE SUFFERED:	**NO**	**YES**	**REMARKS:**
Other bowel problems?			
Hepatitis?			
Other liver problems/Jaundice?			
Diabetes?			
Thyroid problems?			
Other glandular problems?			
Any tropical disease e.g. malaria?			
Glaucoma/other eyesight problems?			
Deafness/other ear/hearing problems?			
Bronchitis?			
Pneumonia?			
Other lung problems?			
Tuberculosis?			
Prostate Problems?			
Kidney stones/disease?			
Other urinary problems?			
Epilepsy?			

Cancer?			
Mental health problems such as anxiety or depression?			
Skin Problems?			
Recurrent back ache?			
Other back problems?			
Arthritis?			
Rheumatic fever?			
Other joint problems?			
Sciatica?			
Anaemia?			

DO YOU HAVE A FAMILY HISTORY OF:	**No**	**Yes**	**Remarks:**
Heart disease?			
High blood pressure?			
Stroke?			
Cancer?			
Diabetes?			
Blood disorders?			

WHAT IS YOUR WEIGHT:	kgs/lbs	HEIGHT:	cms/ins

LIST ALL CURRENT DRUGS THAT YOU ARE TAKING (include inhalers, injections, HRT, contraception pills, & alternative medicines, e.g. homeopathic/herbal).	**LIST ANY ALLERGIES (especially drug/medication)**
LIST ALL PREVIOUS SURGERY (include details of operations, specialist names, hospitals and dates where possible):	**ANY OTHER INFORMATION THAT YOU MAY WISH TO DISCLOSE AND/OR MAY BE USEFUL TO THE DOCTOR**

THANK YOU FOR TAKING THE TIME TO COMPLETE THE APPLICATION FORM.

PLEASE DO NOT FORGET TO ATTACH PHOTOGRAPHS WHEN YOU SEND IN YOUR APPLICATION.
WE WOULD LIKE BOTH PHOTOS OF YOUR CONDITION AND YOU FULLY DRESSED.
WE WILL BE IN TOUCH VERY SOON.

MANY THANKS

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