Passport photos

x2

Application Form

Private and Confidential

Mr/Mrs/Miss/Ms (please delete as appropriate) _____

First name _____ Middle name _____

Surname _____ Date of birth _____

National Insurance number _____

Address _____

_____ Postcode _____

Home tel number _____ Mobile number _____

Email _____

Marital status _____

Next of kin _____

Relationship _____

Address _____

_____ Postcode _____

Phone number _____

Do you have permission to work in the UK YES / NO Do you have a valid Passport YES / NO

Do you have a valid work permit YES / NO

MOBILITY – Do you have access to a car which can be used for work purposes YES / NO

QUALIFICATIONS/TRAINING (LIST ALL YOUR EDUCATION HISTORY)

QUALIFICATIONS	SCHOOL/COLLEGE	GRADE/RESULT	DATES: FROM – TO

RELEVANT TRAINING/QUALIFICATIONS IN HEALTHCARE		CERTIFICATES DATE
Manual handling	YES / NO	
Health and safety	YES / NO	
Basic food hygiene	YES / NO	
First aid	YES / NO	
NVQ levels	YES / NO	
Others (please list)	YES / NO	

EMPLOYMENT HISTORY / WORK EXPERIENCE

Please record all employment, including current employment by other agencies.

Please start with the most recent. **Please note that we shall obtain a reference from your LAST EMPLOYER.**

Employer name, address & tel no.	From	To	Position held, duties and responsibilities	Reason for leaving

REFERENCES

1A) MUST BE YOUR MOST RECENT EMPLOYER WHICH MUST CORRESPOND WITH YOUR EMPLOYMENT HISTORY.

Name of employer _____

Address of employer _____

_____ Postcode _____

Telephone number _____ Fax number _____

Email _____

1B) ANOTHER OF YOUR EMPLOYERS

Name of employer _____

Address of employer _____

_____ Postcode _____

Telephone number _____ Fax number _____

Email _____

2) MUST BE A FELLOW HEALTH CARE PROFESSIONAL WHO DOES NOT LIVE WITH YOU AND IS ABLE TO SUPPLY A CHARACTER REFERENCE OF YOUR PERSONAL AND PROFESSIONAL PROFILE.

Name of employer _____

Address of employer _____

_____ Postcode _____

Telephone number _____ Fax number _____

Email _____

HEALTH DECLARATION

Carers/Support workers are required to complete this Health Declaration. Any positive answers will not necessarily affect your application. Please list any medical conditions (past or present) which may affect your ability to do the job.

OCCUPATIONAL HEALTH ASSESSMENT	YES	NO	DETAILS
Are you in good health?			
How much time have you lost from work due to illness in the last five years? – Please provide details			
Have you ever been treated in hospital for serious illness or surgery? – Please give dates			
Have you been treated in hospital during the last 12 months?			
Do you have any physical disabilities that could affect your ability to carry out your assignment?			
Have you ever left, been retired or denied a job on health grounds?			
Have you ever been denied a driving licence on health grounds?			
Are you a registered disabled person?			
Have you any disability related to your physical or mental health?			
Have you ever suffered from any mental illness, psychological or psychiatric problems?			
Do you get discomfort or pain in the chest or shortness of breath on exercise?			
Have you ever had any problems with your joints, including pain, swelling or stiffness?			
Do you have any difficulty in moving rapidly over short distances?			
Would you have difficulty looking over either shoulder?			
Do you need to wear glasses or contact lenses?			
Do you have any difficulty with your eyesight which is not corrected by glasses or contact lenses?			
Have you any problems working with Visual Display Units?			
Have you any problems working in confined spaces/ using lifts?			
Do you have any difficulty hearing normal conversation?			
Are you taking any medication that makes you dizzy or drowsy?			
Do you have a medical condition affected by changing sleeping patterns or affecting day time sleep?			
Have you suffered from any alcohol or drug related illness or had an alcohol or drug problem?			

HEALTH DECLARATION continued

OCCUPATIONAL HEALTH ASSESSMENT	YES	NO	DETAILS
Are you having or awaiting any treatment at the moment?			
What is the date of your last chest x-ray?			
Are you receiving Medicines, Pills or Tablets from a doctor or on prescription?			

OCCUPATIONAL HEALTH ASSESSMENT

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING?	YES	NO	DETAILS
Heart Problems/Circulatory Illness/Hypertension			
High or Low Blood Pressure			
Diabetes			
Asthma/Hay fever			
Bronchitis/Pneumonia/Pleurisy			
Tuberculosis			
Epilepsy/Fainting Attacks/Blackouts/Fits/Sudden Collapse			
Headaches/Migraine			
Psychiatric Illness/Anxiety/Depression			
Dermatitis/Skin Sensitivity/Psoriasis/Eczema/Allergies			
Back Injury/Back Problems/Back Pains			
Recurrent Infections e.g. Sore Throats/Ear Infections/ Eye Infections			
Hepatitis/Jaundice			

HAVE YOU EVER BEEN VACCINATED, IMMUNISED OR TESTED FOR / AGAINST ANY OF THE FOLLOWING?	YES	NO	DETAILS
Tuberculosis incl BCG, Heaf, Mantoux or Tine			
Rubella (German Measles)			
Poliomyelitis			
Hepatitis B			
Hepatitis B Anitbodies Date and Result			
HIV			
Tetanus			
Typhoid			
Any Other			

DOCTOR INFORMATION

GP Name _____

Address _____

_____ Postcode _____

Telephone number _____

WORK PREFERENCE

To assist us in finding suitable work for you, please place a tick next to all specialties of which you have significant recent experience and are confident to carry out such duties.

Please keep us informed from time to time of all developments in your career as the work we assign to you depends on accurate up to date information.

WORK PREFERENCE: (PLEASE TICK)	
Full time / Part time	
If part time, how many hours per week do you want to work	
Home care and pop-in visits	
Hospitals	
Nursing/Residential Homes	
Morning / Day / Evening / Night Sleeper duty	

CARE/SUPPORT ASSISTANT ABILITY SCHEDULE

Please indicate yes / no in the areas you have had previous experience.

PERSONAL HYGIENE	
Bath/shower/strip wash	Yes/No
Bed bath	Yes/No
Use of bath aids	Yes/No
Shaving	Yes/No
Mouth care(inc. dentures	Yes/No
Care of hair	Yes/No
Care of feet(exc.toe nails)	Yes/No
Care of finger nails	Yes/No
Dressing/undressing	Yes/No

TOILETING	
Continence care	Yes/No
Bedpans/commodes etc.	Yes/No
Changing a catheter bag	Yes/No
Empting catheter bag	Yes/No

MOBILITY	
Maneuvering and handling course	Yes/No
Use of hoists(man./elec)	Yes/No
Use of walking aids	Yes/No

CARE DUTIES	
Pressure area care	Yes/No
Simple dressing procedure	Yes/No
Assisting with medication	Yes/No
Terminal care	Yes/No

PRACTICAL TASKS	
Light house work	Yes/No
Washing personal laundry	Yes/No
Shopping	Yes/No
Bed making/changing bed linen	Yes/No
Collecting benefits	Yes/No

ADMINISTRATION ABILITIES	
Confidentiality	Yes/No
Report writing	Yes/No
Recording instructions from GP/District Nurse	Yes/No
Observing/recording	Yes/No
Changes in clients condition	Yes/No

PREVIOUS EXPERIENCE	
Private house	Yes/No
Nursing/residential home	Yes/No

EQUAL OPPORTUNITIES MONITORING

Reliable Care Services LTD aims to be an equal opportunities employer. Employees are therefore put forward for work / shift irrespective of race, ethnic origin, disability, age and gender. In order to monitor the effectiveness of our policy, we request all candidates to provide the following information.

Name _____

Age Group ☐ 16 – 20 ☐ 21 – 35 ☐ 36 – 50 ☐ 50+

☐ Registered disability ☐ Unregistered disability ☐ No disability

Please tick appropriately which best describes your Ethnic Origin

☐ White European
☐ White Other
☐ Black African
☐ Black Caribbean
☐ Black Other
☐ Indian
☐ Pakistani
☐ Chinese
☐ Other

How did you hear about the post?

_____

Are you related or do you know any member of staff at Reliable Care Services Ltd?

_____

REHABILITATION OF OFFENDERS ACT 1974

You are advised that you are not entitled to withhold information about convictions, which are regarded as spent under the Act'. This is due to the nature of the work involved renders the post exempt from sec. 4(2) of the Act in accordance with the Rehabilitation of Offenders Act 974 (Exceptions) Order 1975.

You are therefore required to give details of all convictions and cautions including 'spent' convictions. Any in formation, which you may give, will be strictly confidential and will be considered only in relation to this or a similar position for which you may be considered with Reliable care services.

Have you ever been convicted of a criminal offence? YES / NO

If yes, please give details of all convictions and cautions, including spent convictions and cautions: (please use a separate sheet if necessary)

_____

_____

_____

_____

You are required to complete the Criminal Records Bureau's (CRB) Disclosure form. All health professionals registered with Reliable Care Services are subject to this disclosure process in the interests of all parties concerned.

DECLARATION

I declare that:

All information given is true in every respect. I have read and understood the Terms and Conditions and I agree to comply with the current Health and safety at work Act

(ii) I have never been charged with, or convicted of an offence under any legislation dealing with Residential care or any offence involving dishonesty or violence.

(iii) I have been issued with a staff handbook and informed of the importance of reading and understanding it.

Signature _____ Date _____

CRIMINAL RECORDS BUREAU – ENHANCED DISCLOSURE

Forenames _____ Surname _____

I understand that before I can commence work with Reliable Care Services LTD, I will need to be in possession of a CRB Enhanced Disclosure.

Signature _____ Date _____

DOCUMENTS NEEDED FOR REGISTRATION

- **VALID WORK PERMIT**

  (Or if Student, College ID and Student Visa).

- **PASSPORT** (or other current Home Office Document authorizing you to work in UK).

- **NATIONAL INSURANCE (NI) CARD**

  (Or P45 or P60 or letter confirming you have applied for NI.

- **PROOF OF ADDRESS**

  E.g. Driving Licence, Utility Bill, or any formal letter with your name and address.

  Not more than three months old.

- **3 CURRENT PASSPORT SIZE PHOTOGRAPHS**

- **CRIMINAL RECORDS BUREAU CERTIFICATE (DBS)** you apply with us.

- **TRAINING CERTIFICATES** e.g. Moving & Handling, Basic Aid etc. If you do not have the certificates we can provide training.

BANK DETAILS

Name _____

Account name _____

Bank name _____

Bank address _____

Account number _____

Sort code _____

Signature _____ Date _____

WORKING TIME REGULATION – OPT OUT FROM 48 HOUR RULING

The working time regulation came into effect on 1 October 1998. One of the main provision of the regulation states that employees other than managing executives or employees with autonomous decisions making powers may not be required to work in excess of 48 hours per week averaged over a seventeen-week reference period.

While Reliable Care Services positively discourages the working of excessive hours, it recognizes that individual employees may wish to exercise their right to opt out of the 48 hours ruling. Employees who wish to Opt out should complete this form and return it to the personnel department.

Full Name _____

Job Title: _____

Department: _____

I wish to exercise my right to opt out of the 48 hour riling contained within the working time regulation and understand that in normal circumstances I will be required to give four weeks' notice in event that I wish to withdraw from this agreement.

Signed _____ Date_____

DATA PROTECTION STATEMENT

- I declare that the information I have given in this application is accurate and true. I understand that providing misleading or false information or false information will disqualify me from appointment OR, if appointed, may result in summary dismissal.
- I declare that I have not omitted to disclose information relevant to this application
- I confirm my agreement with arrangements in relation to the processing of Enhanced Criminal Disclosure applications.
- I confirm my agreement with practices in relation to the processing and handling of personal sensitive information contained within this application

Full Name _____

Job Title: _____

Signed _____ Date_____

NIGHT WORKERS HEALTH ASSESSMENT QUESTIONNAIRE

A night worker is an employee who is scheduled to work at least 3 hours of his/her daily working time during night time on the majority of days on which he/she is scheduled to work. Night time is defined as the period between 11 pm and 6 am.

The purpose of the questionnaire is to ask whether you have any health problem which could be affected by night work, so that where necessary an appropriate medical review can be arranged. The questionnaire will be confidential but a report on your fitness will be provided to your manager who is responsible for work assignments and for the arrangements for health and safety at work.

Please complete the form and tick the appropriate box for the questions listed; if you have any other condition which you believe should be considered please write brief details at the bottom of the page or continue on a separate sheet of paper.

	YES	NO
Have you had any medical problem in the past which has prevented you from working at night?		
Are you diabetic?		
Are you subject to angina, or other heart problems which may affect your fitness?		
Are you suffering from any circulatory problems which affect your activities?		
Have you had duodenal or stomach ulcers in the past, or under treatment at present?		
Have you had any continuing bowel problem, for instance following major surgery?		
Do you have any chronic chest problem such as asthma, emphysema or bronchiectasis?		
Do you have any disability affecting mobility which will cause difficulties in arranging night work?		
Do you have any recurrent or continuing sleep disturbance requiring medical advice?		
Are you having specialist care requiring your attendance at hospital clinics for treatment?		
Do you have any other health problem which affects your fitness for night work?		
Are you taking any medication to a strict timetable? If yes give details on a separate sheet		

Please give any further details which you would like to bring to our attention:

Full Name _____

Signed _____ Date _____