**APPLICATION FORM**

##  PLEASE PRINT IN BLACK INK

**Application Date:**

## PERSONAL DETAILS

|  |  |
| --- | --- |
| **Title:** | **First Name:** |
| **Middle Name:** | **Last Name:** |
| **DOB:****Age:** | **/ /****Gender:** | **National Insurance Number:** |
| **Address:** | **Next of Kin:** |
|  | **Address:** |
| **Day Tel. No.:** | **Telephone No.:** |
| **Mobile No.:** | **Relationship:** |
| **Email Address:** | **Nationality:****Ethnic Origin:** |
| **Position Applied For:** |

**EMPLOYMENT ELIGIBILITY AND COMPLIANCE**

|  |  |  |
| --- | --- | --- |
| **Do you require a work permit:****Yes / No** | **Work permit held: Yes / No** | **Type of work permit held:****Expiry Date: / /** |
| **If student, name of****institution:** | **Do you have a current UK****driving license?****Yes / No** | **Home Office Letter****Reference:** |
| **Do you belong to a union: Yes/No** | **Name of Union:** | **Membership No:** |

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**EMPLOYMENT HISTORY**

### Present or most recent employment

|  |
| --- |
| **Name of employer: Address:** |
| **Job Title** |
| **Main Duties:** |
| **Date started: / / Salary:****Date Left: / / Reason for leaving:** |

**Previous employment or work experience (Including voluntary/unpaid work) *Please fully explain any gaps in employment***

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of employer****and Address** | **Job title & Description** | **Start Date/****End Date** | **Reason for leaving** |
|  |  |  |  |
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## RELEVANT QUALIFICATIONS AND TRAINING

|  |  |  |
| --- | --- | --- |
| **Qualification/Course** | **Training establishment** | **Date obtained** |
|  |  |  |
|  |  |  |
|  |  |  |

**PERSON SPECIFICATION**

Please use the space below to tell us about your experience, skills and knowledge for the job you are applying for, consult the person specification to complete this section.

*(Use additional sheet if necessary)*

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## REFEREES

|  |  |  |
| --- | --- | --- |
|  | **1st Referee (Current/Most****recent)** | **2nd Referee** |
| **Title & Full Name:** |  |  |
| **Job Title:** |  |  |
| **Full Address & Postcode:** |  |  |
| **Telephone:** |  |  |
| **Fax:** |  |  |
| **Email:** |  |  |
| **Relationship:** |  |  |
| **Can Referee be****approached** | Yes/No | Yes/No |
|  |  |  |

|  |  |  |
| --- | --- | --- |
|  | **3rd Referee**  | **4th Referee** |
| **Title & Full Name:** |  |  |
| **Job Title:** |  |  |
| **Full Address & Post code:** |  |  |
| **Telephone:** |  |  |
| **Fax:** |  |  |
| **Email:** |  |  |
| **Relationship:** |  |  |
| **Can Referee be approached** | Yes/No | Yes/No |

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## REHABILITATION OF OFFENDERS ACT 1974

This post is exempt from the provisions of section 4.2 of the rehabilitation of offenders ACT 1974 due to the nature of the work you are applying; therefore, applicants are not entitled to withhold any information about their convictions or criminal offences

|  |
| --- |
| **Have you ever been convicted or cautioned for any criminal offence? Yes / NO** |
| **If yes, please give details (Include any spent convictions):** |
| **Is there any court action pending against you? Yes / No** |

## DECLARATION

I declare that the above information is correct and I consent to Springwood Healthcare checking the details I have provided in support of my application

### Signature..........................................................................................Date............................

Please note that if any of the information you have declared is found to be false or you willing fully omit any relevant material facts, you may be dismissed from your job if appointed.

## EQUAL OPPORTUNITIES

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Birth: / /** | **Age:** | **Gender:** | **Male / Female** |
| **I consider myself to be (please circle):** |
| **White****1****2****3** | **British Irish****Other (specify below)** | **Mixed****4****5****6****7** | **White & Black Caribbean White & Black African White & Asian****Others (specify below)** | **Black or Black British**1. **Caribbean**
2. **African**
3. **Other (specify below)**
 |
| **Asian or Asian British**1. **Indian**
2. **Pakistani**
3. **Bangladeshi**
4. **Other (specify below)**
 | **Chinese or another ethnic group**1. **Chinese**
2. **Other (specify below)**
 | **Other options****17 Prefer not to say** |
| **Please state your religion:** |
| **Do you consider yourself to have a disability: Yes / No?****If yes, please specify:** |

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**EMPLOYMENT GAP ANALYSIS**

| From(month/ Year) | To(month/ Year) | **Reason for the Gap** |
| --- | --- | --- |
|  |  |  |
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**CONFIDENTIAL MEDICAL QUESTIONAIRE**

The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake the duties of the post you have been offered or place you at any risk in the workplace. We may recommend adjustments or assistance as a result of this assessment to enable you to do the job. Our aim is to promote and maintain the health of all people at work. Your record will be held on file for a short period of time and may be subject to audit.

 **PERSONAL INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Title | Surname | First names | DOB |
| Miss/Mrs. |  |  |  |
| Home Tel: | Work Tel: | Mobile: |
| Home Address: | GP Address: |

|  |  |  |
| --- | --- | --- |
| **All staff groups complete this section** | Yes | No |
| Do you have any illness/impairment/disability (physical or psychological) which may affect yourwork? |  |  |
| Have you ever had any illness/impairment/disability which may have been caused or made worse byyour work? |  |  |
| Are you having, or waiting for treatment (including medication) or investigations at present? If youranswer is yes, please provide further details of the condition, treatment and dates |  |  |
| Do you think you may need any adjustments or assistance to help you to do the job? |  |  |

 If you have indicated yes to any of the above questions you must provide further details in additional information section, failure to do so will result in the form being **returned/rejected**.

|  |
| --- |
|  |

 **Tuberculosis**

|  |  |  |
| --- | --- | --- |
| Clinical diagnosis and management of tuberculosis, and measures for its prevention and control(NICE 2006) | Yes | No |
| Have you lived continuously in the UK for the last year (**Include Holidays/ Vacations**) |  |  |
| **If you answered NO to the above, please list all of the countries that you have lived in/visited over the last year, including holidays and vacations. This MUST include duration of stay and dates or this form will be rejected.** |
| Have you had a BCG vaccination in relation to Tuberculosis? |  |  |
| If you answered yes, please state when | Date |  |

 **Tuberculosis Continued**

|  |  |  |
| --- | --- | --- |
| Do you have any of the following | Yes | No |
| A cough which has lasted for more than 3 weeks |  |  |

|  |  |  |
| --- | --- | --- |
| Unexplained weight loss |  |  |
| Unexplained fever |  |  |
| Have you had tuberculosis (TB) or been in recent contact with open TB |  |  |

Additional Information

|  |
| --- |
| **If you answered NO to the above, please list all of the countries that you have lived in/visited over the last year, including holidays and vacations. This MUST include duration of stay and dates or this form will be rejected.** |

|  |
| --- |
| **Chicken Pox or Shingles** |
| Have you ever had chicken pox or shingles |
| **Yes** | **No** | **Date** |
|  |  |  |

|  |
| --- |
| **Immunization History** |
| Have you had any of the following immunizations | **Yes** | **No** | **Date** |
| Triple vaccination as a child (Diphtheria / Tetanus / Whooping cough) |  |  |  |
| Polio |  |  |  |
| Tetanus |  |  |  |
| Hepatitis B (If yes is ticked please give dates below) |  |  |  |
| Course: | 1 |  | 2 |  | 3 |  |
| Boosters: | 1 |  | 2 |  | 3 |  |

|  |
| --- |
| **Proof of Immunity (Please send the following)** |
| **Varicella** | You must provide a written statement to confirm that you have had chicken pox or shingles however we **strongly advise** that you provide serology test result showingvaricella immunity |
| **Tuberculosis** | We require an occupational health/GP certificate of a positive scar or a record of apositive skin test result **(Do not Self Declare)** |
| **Rubella, Measles & Mumps** | Certificate of **“two”** MMR vaccinations or proof of a positive antibody for Rubellaand Measles |
| **Hepatitis B** | You must provide a copy of the most recent pathology report showing titre levels of100lu/l or above |

**DBS APPLICATION FORM**

|  |
| --- |
| **Personal Details** |
| Title: Mr., Mrs., MS, Miss |  |
| Name stated on passport: |  |
| Surname: |  |
| DOB: |  | NI Number: |  |
| Nationality at Birth: |  | Town andCountry of Birth: |  |
| Change of Forename (M/Y) | / | Change ofSurname: |  |
| Passport Number: |  | Passport Expiry &Issue date: |  |
| Nationality |  | UnspentConvictions |  |

Address History

Please provide your address details for the past 5 years

|  |  |  |
| --- | --- | --- |
| Current Address: |  | From (MM/YY)To (MM/YY) |
| Previous Address: |  | From (MM/YY)To (MM/YY) |
| Previous Address: |  | From (MM/YY)To (MM/YY) |
| Previous Address: |  | From (MM/YY)To (MM/YY) |

|  |  |
| --- | --- |
| Are you working or intending to work with children? | YES NO |
| Are you working or intending to work with vulnerable adults? | YES NO |

|  |
| --- |
| Declaration |
| Signed: |  |
| Print Name: |  |
| Date: |  |

Registration Documents

 Thank you for your interest in our agency.

The following are the list of documents we require for you to register with us

* Passport /Birth Certificate
* Employment History
* Training Certificates e.g., Care certificate, Mandatory training.
* Copy of your Diploma/degree and any other qualifications you may hold.
* 2 passport size photographs for ID card
* Proof of Address – Utility bill/ Bank statement within 3months
* Name, Addresses & Telephone Numbers of 2 people who can provide you with employment references or 3-character references.
* Provision of National Insurance Number
* DBS certificate OR Update service number Or Police Report
* Bank details

**Additional Information**

**PAYMENT DETAILS**

|  |  |
| --- | --- |
| **Bank Name** |  |
| **Account Name** |  |
| **Account No.** |  |
| **Sort Code** |  |
| **Building Society Roll No.** |  |

I authorize springwood Healthcare l to pay my earnings directly into my building society or bank account number that I have given above. I confirm that I will inform Springwood healthcare in writing of any changes to the above details.

### Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_