



CARERS APPLICATION FORM

APPLICATION FORM- (COMPLETE IN BLACK INK AND BLOCK CAPITALS ONLY)

SURNAME: _____ FORENAMES: _____

ADDRESS: _____

ADDRESS 2: _____

COUNTY: _____ POST CODE: _____

MOBILE NUMBER: _____ HOME NUMBER: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: ____/____/____ MARITAL STATUS: _____

NATIONAL INSURANCE NUMBER: _____ NATIONALITY: _____

ARE YOU ALLOWED TO WORK IN THE UK? YES / NO _____ VISA STATUS: _____

LANGUAGES SPOKEN EXCLUDING ENGLISH: _____

NEXT OF KIN DETAILS:

NAME:	RELATIONSHIP:
ADDRESS:	TELEPHONE:
	EMAIL ADDRESS:

PLEASE SPECIFY YOUR AVAILABILITY (Please circle available days)

MON	TUES	WED	THUR	FRI	SAT	SUN
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MORNING/LUNCH CALL	TEA TIME/BEDTIME CALL
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ARE YOU INTERESTED IN ANY OF THE FOLLOWING ROLES? (Please circle roles)

LIVE IN

SIT IN

WAKE IN

EXPERIENCE AND EMPLOYMENT HISTORY

(PLEASE INDICATE YOUR AREAS OF EXPERIENCE BY TICKING THE APPROPRIATE BELOW)

Incontinence care		Managing people with HIV/AIDS		Managing aggression	
Managing terminally illness		Managing people with learning disability		Managing depression	
Managing people with mental health problems		Managing challenging and anti-social behaviour		Managing specialist lifting and handling techniques	
Managing people with sensory loss and sensory impairment		Managing people with alcohol and drugs misuse		Other experience, please indicate	

EMPLOYMENT HISTORY

PLEASE GIVE DETAILS OF ALL PREVIOUS EMPLOYMENT AND GIVE REASONS FOR ANY GAPS SUCH AS UNEMPLOYMENT, VOLUNTARY WORK AND RAISING OF FAMILY.

A. EMPLOYER

NAME AND ADDRESS:

.....

FROM: TO:

POSITION HELD:.....SALARY.....

DUTIES AND RESPONSIBILITIES:.....

.....

REASONS FOR LEAVING:.....



B. EMPLOYER

NAME AND ADDRESS:

FROM: _____ TO: _____

POSITION HELD: _____ SALARY _____

DUTIES AND RESPONSIBILITIES: _____

REASONS FOR LEAVING: _____

FURTHER EDUCATION AND TRAINING:

QUALIFICATION OBTAINED		
DATES	FROM:	TO:

REFERENCES

Please provide a minimum of **TWO** reference one of which **MUST** be from your current employer, use block capitals.

NAME:		NAME:	
POSITION:		POSITION:	
COMPANY:		COMPANY:	
ADDRESS:		ADDRESS:	
TELEPHONE:		TELEPHONE:	



EMAIL ADDRESS:		EMAIL ADDRESS:	

Home Office circular HOC10/88

All applicants must answer all the questions on this form. Failure to do so will invalidate your application.

In accordance with the above circular you are required to provide the following information which will be passed on to the police authorities to check the existence and content of any criminal record.

Due to the nature of the work for which you are required, jobs and assignments are exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974(Exemption)(Amendments) Order 1986. Applicants are, therefore, not entitled to withhold information about convictions, reprimands or final warnings which, for other purposes, are "spent" under the provisions of the Act and in the event of employment, any failure to disclose such convictions could result in removal from Care Connexions UK.

Please note that this information will only be provided to and checked with the police authorities after a recruitment interview has taken place.

Please answer the following questions using **BLOCK CAPITALS ONLY**:

HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENCE, CAUTIONED, SENTENCED, REPRIMANDED OR GIVEN A FINAL WARNING YES/NO

IF YES, PLEASE PROVIDE DETAILS: _____

FULL NAME: _____

SIGNATURE: _____ DATE: ____/____/____

DISCIPLINARY ACTION

Have you ever been subject to disciplinary action YES/NO

If yes, please give details:

DECLARATION

If you provide false or misleading information to support your application it will disqualify you from being engage as care worker for Care Connexions UK.

I hereby declare that I have understood and complied with the requirements laid down in the application and I agree that the information given on this form may be used in obtaining a DBS on me from the policy authorities.



Name: _____ Signature: _____

Date: ____/____/____

CONFIDENTIAL HEALTH QUESTIONNAIRE

Please complete the health questionnaire and return with the completed job application form. All the information given will be treated as confidential and will not be shared with the third party without your consent.

Please answer all the following questions by ticking the appropriate box, if your answer to any questions is yes, please give further details.

Part A

	Have you ever had any of the following?	YES	NO	DETAILS
1	Eczema dermatitis or other skin conditions			
2	Discharge or infection of the ears or defects of hearing			
3	Eye conditions or injuries or defects of sight			
4	Asthma, hay fever or any other allergic conditions, including sensitivity to antibiotics			
5	Recurrent sore throat or sinusitis			
6	Tuberculosis bronchitis or pneumonia			
7	Episodes of severe chest pain or breathlessness			
8	Heart disease or high blood pressure			
9	Severe headaches			
10	Fits blackouts or epilepsy			
11	Gastric or duodenal ulcers or frequent or prolonged indigestion			
12	Hepatitis or jaundice			
13	Prolonged back pain or disc problems			
14	Arthritis or rheumatism			
15	Difficulties in bending or lifting			



16	Kidney or bladder infections			
17	Diabetes			
18	Varicose veins			
19	Depression, mental illness or nervous break down			
20	Operations			
21	Accidents at work or elsewhere requiring admission to hospital			
22	Any other conditions requiring hospital treatment or investigation as an In Patient or Out Patient			
23	Absences from work or school due to ill-health during the past year			

PART B

		Yes	No	Details
1	Are you currently taking or receiving any form of medication			
2	Do you smoke?			
3	Do you drink alcohol?			
4	Are you registered disabled or in receipt of disability allowance			
5	Do you normally wear glasses or contact lenses?			
6	How many days have you lost through sickness in the last year?			

Name and address of your GP: _____

Post Code: _____

Telephone Number: _____

Declaration:

I know of no health reason that will affect my ability to undertake the duties required of me in the position for which I am applying. All the answers given on this form are true and correct to the best of my knowledge.



Signature of candidate _____

EQUAL OPPORTUNITIES POLICY

Care Connexions UK is committed to promoting equal opportunity. Our policy is to ensure that job applicants and employees receive equal treatment irrespective of their race, colour, gender, age or disablement. By completing all sections of this form you will help us to monitor the effectiveness of our equal opportunities policy. All information will be held in strict confidence.

MONITORING CHECK LIST

Gender

Male		Female	
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National/Racial Origin

Asian		Black		White	
Pakistani		African		British	
Bangladeshi		Caribbean		European	
Indian		British		Other	
Other		European			
		Other			

Disability

Do you consider yourself as having a disability that could affect your day-to-day work?
 YES/NO

If yes, please give details: _____

FOR OFFICE USE ONLY

Passport seen: Yes No _____ Passport Number: _____

Driving licence seen: Yes No Diving license no: _____



DBS Reference number: _____ Issue Date: _____

National Insurance number see: Yes No

Immigration status: _____

VACCINATION CERTIFICATES/REPORT: _____

BANK DETAILS

FULL NAME: _____

SORT CODE: _____ ACCOUNT NUMBER: _____

BRANCH: _____

CURRENT ACCOUNT OR BUILDING SOCIETY