CANDIDATE NAME:

POSITION BEING APPLIED FOR:

# 

**APPLICATION & REGISTRATION DOCUMENT CHECKLIST**

Please ensure you provide the following documents for completion of your registration and application with Phebdan Healthcare Services

* Passport/Birth Certificate/Driver’s Licence \*
* Proof of Address (e.g. rent receipt, utility bill)
* Original certificates/diplomas/NVQ Qualification
* Certificates of training received in Domiciliary Care
* 2 passport photographs
* Bank/Building Society details
* CRB Enhanced Disclosure check
* National Insurance card/P45/P60
* Current Curriculum Vitae (CV)

\* Only one of these items will be required for the purpose of identification.

Please also bear in mind the following when completing your application form and submitting the items required:

* Passport Photos

Please ensure that you write your name at the back of your passport photos.

* Employment History

Your employment history must be continuous, starting with your current or most recent employers; this must date back to the last five years. Any gaps in your employment history must be explained; you can note the explanation in the ‘Duties and Responsibilities Section.

If you need to continue your employment history on a separate sheet, please request an Employment History Continuation Sheet

* References

You must provide two Professional Referees from your current or most recent employers. These Referees must have worked with you in a senior capacity and they should also be able to attach their company stamp or logo on the reference letter as well as be able to be contacted in order to verify that they completed the reference letter

PLEASE COMPLETE IN BLOCK CAPITALS ONLY

## PERSONAL DETAILS

|  |  |  |  |
| --- | --- | --- | --- |
| SURNAME: | TITLE: | | FORENAME: |
| PREFFERED NAME: | | | |
| OTHER NAMES BY WHICH YOU ARE KNOW: | | | |
| ADDRESS: POST CODE: | | | |
| TELEPHONE (HOME): | | MOBILE: | |
| EMAIL ADDRESS: | | DATE OF BIRTH: | |
| NATIONALITY: | | NATIONAL INSURANCE NUMBER: | |
| ARE YOU ELIGIBLE TO WORK IN THE UK: YES NO | | | |
| IF YES, STATE VISA STATUS: | | DATE OF ENTRY INTO THE UK: (DD/MM/YYYY) | |

## NEXT OF KIN DETAILS

|  |  |  |
| --- | --- | --- |
| NAME: | | RELATIONSHIP: |
| ADDRESS: | MOBILE: | |
| CONTACT #: | |

|  |  |
| --- | --- |
| **OTHER LANGUAGE(S) SPOKEN:** | |
| **POSITION BEING APPLIED FOR**: | |
| **AVAILABILITY**: Full Time Part Time | |
|  | |
|  | |
|  | |
|  | DO YOU DRIVE YOUR OWN CAR? YES NO |
| Are you interested and available to do any of the following: LIVE-IN SIT-IN WAKE IN SLEEP IN | |

**EXPERIENCE**

Please indicate your areas of experience

NO EXPERIENCE/NEW TO HEALTH CARE INCONTINENCE MANAGEMENT MANAGING PEOPLE WITH TERMINAL

ILLNESS

MANAGEMENT OF AGGRESSION MANAGING PEOPLE WITH HIV/AIDS MANAGING PEOPLE WITH LEARNING

DIFFICULTIES

MANAGING PEOPLE WITH PEOPLE WITH SENSORY LOSS AND SENSORY IMPAIRMENT

MANAGING PEOPLE WITH MENTAL

MANAGING LIFTING & HANDLING EQUIPMENT

MANAGING PEOPLE WITH CHALLENGING & ANTI-SOCIAL BEHAVIOUR

MANAGING PEOPLE WITH PHYSICAL DISABILITIES

MANAGING PEOPLE WITH DEPRESSION MANAGING PEOPLE WITH MENTAL

HEALTH PROBLEMS INCLUDING DEMENTIA MANAGING PEOPLE WITH ALCOHOL AND

DRUGS MISUSE

## EDUCATION AND TRAINING

Please give details of relevant training courses and /or qualifications that you have completed, starting with the most recent

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ORGANISING BODY | COURSE TAKEN | FROM  (mm/yyyy) | TO  (mm/yyyy) | ATTAINMENT |
|  |  |  |  |  |

## EMPLOYMENT HISTORY

Please give details of all your previous employment (at least 5 years), starting with the most recent. You must give reasons for any gaps such as unemployment, voluntary work, and leave to raise family etc. (continue on a separate sheet if necessary)

|  |  |
| --- | --- |
| EMPLOYER NAME AND ADDRESS: | DUTIES AND RESPONSIBILITIES: |
| POSITION HELD: |
| DURATION EMPLOYMENT |
| REASON FOR LEAVING: | |

## EMPLOYMENT HISTORY CONTINUED

|  |  |
| --- | --- |
| EMPLOYER NAME AND ADDRESS: | DUTIES AND RESPONSIBILITIES: |
| POSITION HELD: |
| DURATION EMPLOYMENT |
| REASON FOR LEAVING: | |

|  |  |
| --- | --- |
| EMPLOYER NAME AND ADDRESS: | DUTIES AND RESPONSIBILITIES: |
| POSITION HELD: |
| DURATION EMPLOYMENT |
| REASON FOR LEAVING: | |

|  |  |
| --- | --- |
| EMPLOYER NAME AND ADDRESS: | DUTIES AND RESPONSIBILITIES: |
| POSITION HELD: |
| DURATION EMPLOYMENT |
| REASON FOR LEAVING: | |

**REFERENCES**

Please detail **TWO PROFESSIONAL** referees from your current or most recent employment

|  |  |
| --- | --- |
| Reference 1  NAME: | Reference 2  NAME: |
| POSITION: | POSITION: |
| ORGANISATION: | ORGANISATION: |
| ADDRESS: | ADDRESS: |
| CONTACT NUMBER: | CONTACT NUMBER: |
| EMAIL ADDRESS: | EMAIL ADDRESS: |

## BANK OR BUILDING SOCIETY DETAILS

|  |
| --- |
| **FULL NAME** |
| **BANK ACCOUNT DETAILS**  NAME OF BANK |
| BRANCH |
| SORT CODE |
| ACCOUNT NUMBER |
| **BUILDING SOCIETY DETIALS**  NAME OF BUILDING SOCIETY |
| BRANCH |
| SORT CODE |
| ACCOUNT NUMBER |
| BUILDING SOCIETY ROLL NUMBER |

**CONFIDENTIAL HEALTH QUESTINNAIRE**

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

All the information given in this form will be treated as confidential and will not be divulged to a third party without your consent.

|  |  |  |
| --- | --- | --- |
| SECTION A Have you ever had any of the following? | | |
| 1. Eczema, dermatitis or other skin condition | YES | NO |
| 2. Discharge or infection of the ears or defects of hearing | YES | NO |
| 3. Eye conditions or injuries or defects of sight | YES | NO |
| 4. Asthma, hay fever or any other allergic conditions, including sensitivity to antibiotics | YES | NO |
| 5. Recurrent sore throats or sinusitis | YES | NO |
| 6. Recurrent sore throats or sinusitis | YES | NO |
| 7. Tuberculosis, bronchitis, or pneumonia | YES | NO |
| 8. Episodes of severe chest pain or breathlessness | YES | NO |
| 9. Heart disease or high blood pressure | YES | NO |
| 10. Severe headaches | YES | NO |
| 11. Fits, blackouts, or epilepsy | YES | NO |
| 12. Gastric or duodenal ulcers or frequent or prolonged indigestion | YES | NO |
| 13. Hepatitis or jaundice | YES | NO |
| 14. Prolonged back pain or disc problems | YES | NO |
| 15. Arthritis or rheumatism | YES | NO |
| 16. Difficulties in bending or lifting | YES | NO |
| 17. Kidney or bladder infections | YES | NO |
| 18. Diabetes | YES | NO |
| 19. Varicose veins | YES | NO |
| 20. Depression, mental illness, or nervous breakdowns | YES | NO |
| 21. Operations | YES | NO |
| 22. Accidents (at work or elsewhere) requiring admission to hospital | YES | NO |
| 23. Any other conditions requiring hospital treatment or investigation as an in-patient or out-patient | YES | NO |
| 24. Absences from work or school due to ill health during the past year | YES | NO |

|  |  |  |
| --- | --- | --- |
| **CONFIDENTIAL HEALTH QUESTINNAIRE CONTINUED**  SECTION B | | |
| 25. Are you currently taking or receiving any form of medication? | YES | NO |
| 26. Do you smoke? | YES | NO |
| 27. Do you drink alcohol? | YES | NO |
| 28. Are registered disabled or in receipt of a disability allowance? | YES | NO |
| 29. Do you normally wear glasses or contact lenses? | YES | NO |
| 30. How many days have you lost through sickness in the last year? | YES | NO |

If you have answered YES to any of the questions above, please use the space below to provide further details

NAME AND ADDRESS OF YOUR GP:

TELEPHONE NUMBER:

|  |  |  |
| --- | --- | --- |
| **HEALTH 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: | Print Name: | Date: |

**DISABILITY**

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

## EQUAL OPPORTUNITIES POLICY

Phebdan healthcare Services Limited is committed to promoting Equal Opportunities. 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.

## EQUAL OPPORTUNITIES POLICY – MONITORING CHECKLIST

For the purpose of monitoring our Equal Opportunities policy as stated above, please complete the following:

**GENDER**

Male

Female

**NATIONAL/RACIAL ORIGIN**

Asian Pakistani Bangladeshi Indian Other

If you have selected ‘Other’, please detail

White

British European Other

Black

African Caribbean British European Other

If **YES**, please give details

YES

NO

If YES, please give details ( use additional sheets if necessary)

**DISCIPLINARY ACTION**

Have you ever been subject to any disciplinary action?

|  |  |
| --- | --- |
| **HOME OFFICE CIRCULAR HOC 102/88**  ALL APPLICANTS MUST ANSWER ALL 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.  Because of 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 (Exemptions) (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 Phebdan Healthcare Services’ list of employees.  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 by the police? YES NO | |
| If YES, please give details (use additional sheets if necessary) | |
| FULL NAME: | |
| CURRENT ADDRESS: | |
| I HAVE LIVED AT THE ABOVE ADDRESS SINCE: | |
| PREVIOUS ADDRESS (must cover previous 5 years) | |
| DATE OF BIRTH: | PLACE OF BIRTH: |
| YOUR MAIDEN NAME: |  |
| ANY OTHER IDENTIFYING PARTICULARS: | |

|  |  |  |
| --- | --- | --- |
| **WORKING TIME REGULATIONS**  The European Union has laid down guidelines for all workers, governing maximum length of the working week for which it is safe to work. The current limit is 48 hours per week. You are under no obligation to accept work offered and you will never be compelled to work more than 48 hours per week, but you may choose to do so.  Please sign below to confirm that you have read and understood this information, indicating your preference by ticking the appropriate option.  I have read this information regarding the Working Time Regulations and I understand that I do not have to work more than 48 hours per week   1. I DO NOT wish to work more than 48 hours per week 2. I DO wish to work more than 48 hours per week. I understand that I may withdraw this consent at any time by giving seven days’ notice to Phebdan healthcare Services Ltd and signing a new form | | |
| Signature: | Print Name: | Date: |

|  |  |  |
| --- | --- | --- |
| **RIGHT TO WORK ENQUIRY AGREEMENT**  I agree and give permission for Phebdan healthcare Services Ltd to take appropriate action and contact the appropriate authorities as part of their efforts to validate my Right to Work in the UK. | | |
| Signature: | Print Name: | Date: |

|  |  |  |
| --- | --- | --- |
| **CONFIDENTIALITY AGREEMENT**  I agree that during the time I am engaged by Phebdan Healthcare Services Ltd to work in any capacity:   1. I will not disclose to any person, any information obtained whilst attending an assignment. 2. I will hold in trust and confidence for Phebdan Healthcare Services Ltd, all such information, and never use it other than for the benefit of Phebdan Healthcare Services Ltd | | |
| Signature: | Print Name: | Date: |

|  |  |  |
| --- | --- | --- |
| **DECLARATION**  If you provide false or misleading information to support your application, it will disqualify you from being engaged as an employee by Phebdan Healthcare Services Ltd.  If it is found that you provided false or misleading information to support your application after or during your employment, Phebdan Healthcare Services holds the right to terminate your contract on this basis.  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 to obtain CRB check on me from the policy authorities. | | |
| Signature: | Print Name: | Date: |

|  |  |  |
| --- | --- | --- |
| **ADDITONAL NOTES**  Please use this section to detail any further information that supports your application. | | |
| Signature: | Print Name: | Date: |

# FOR OFFICE USE ONLY

**Reference 1**

Sent: Date: Received: Date:

Verification of Reference 1

Person Contacted: Date:

Completed by: Date:

**Reference 2**

Sent: Date: Received: Date:

Verification of Reference 2

Person Contacted: Date:

Completed by: Date:

**Relevant Immigration Documents seen**: Date:

**Proof of NI seen**:  Date: **Passport seen**:  Date: CRB **payment**:  Date: **CRB sent**:  Date: Uniform **Issued**:  Date: **ID Badge Issued**:  Date:

Notes: