



# Personal application form

MAGGIE HEALTHCARE LTD  
80 Teversham Lane  
Stockwell  
London  
Sw8 2dp  
United Kingdom  
[www.maggiehealthcare.com](http://www.maggiehealthcare.com)  
Tel: 07590696283  
Email: [info@maggiehealthcare.com](mailto:info@maggiehealthcare.com)

## CARE STAFF APPLICATION FORM

Please use CAPITAL LETTERS throughout.

### PERSONAL DETAILS

Title: \_\_\_\_\_ Surname \_\_\_\_\_

Forename: \_\_\_\_\_ Maiden Name \_\_\_\_\_

\_\_\_\_\_

Middle Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_

\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

\_\_\_\_\_

Age: \_\_\_\_\_ National Insurance: \_\_\_\_\_

Address: \_\_\_\_\_

City / Town: \_\_\_\_\_ Country: \_\_\_\_\_

Postcode: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

Mobile phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Pager No: \_\_\_\_\_ Email Address: \_\_\_\_\_

Preferred Contact Method \_\_\_\_\_

Are you willing to accept morning calls? \_\_\_\_\_ Yes .....No \_\_\_\_\_

Are you willing to expect late-night calls? \_\_\_\_\_ Yes: No \_\_\_\_\_

### **VARIOUS INFORMATION**

Work status \_\_\_\_\_ Passport Number: \_\_\_\_\_ Exp date: / / \_\_\_\_\_

Nationality \_\_\_\_\_ Birth certificate No: \_\_\_\_\_

Home Office Letter ref: \_\_\_\_\_ Have Work Permit? Yes No \_\_\_\_\_

Work Permit Type \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name of college/university (if student) \_\_\_\_\_

Do you have your transport? \_\_\_\_\_ Type of Transport:? \_\_\_\_\_

Have you got a driving license?: \_\_\_\_\_ If yes any endorsement? \_\_\_\_\_

Religion \_\_\_\_\_ Ethnic Origin \_\_\_\_\_

Children under 18 years? \_\_\_\_\_ Ages \_\_\_\_\_

Do you smoke? Yes No \_\_\_\_\_ Registered Disabled? Yes No \_\_\_\_\_

Registration No: \_\_\_\_\_

Give details of hobbies/leisure activities

---



---



---



---



---



---



---



---

**PROFESSIONAL EDUCATION AND TRAINING.**

Please list any Training / Course/healthcare qualification you have and when you gained them

Qualification: \_\_\_\_\_ School / College, University. \_\_\_\_\_

Dates \_\_\_\_\_

.....

.....

.....

.....

.....

.....

.....

**Please tick the specialities of which you have significant, post training experience. Please remember you have held accountable for any missing information.**

Hospitals				
Learning Disability				
Adolescents				
Children				
Mental health				
Elderly				
Physical disability				
HIV				

Residential Homes				
Nursing homes				

**EMPLOYMENT HISTORY**

**Please give details of your past 5 years of continuous work history, giving reasons/s for any breaks in employment**

**From**        /        /        **To**        /        /

Employer \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ Main contact \_\_\_\_\_

Post Title: \_\_\_\_\_ Grade \_\_\_\_\_

Full-time or part-time \_\_\_\_\_ Salary: \_\_\_\_\_

Main responsibilities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**From**        /        /        **To**        /        /

Employer \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ Main contact \_\_\_\_\_

Post Title: \_\_\_\_\_ Grade \_\_\_\_\_

Full time or part-time \_\_\_\_\_ Salary: \_\_\_\_\_

Main responsibilities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## HEALTH DECLARATION

Have you been vaccinated or tested against the following:	YE S	N O	DETAILS (Plus dates if YES)
Hepatitis B			
HIV			
Tetanus			
Poliomyelitis			
Typhoid			
Rubella (German Measles)			
Tuberculosis and BCG			
Hepatitis B Antibodies			
Mantoux, tine or Heaf			
Varicella			
Last X-ray			
Others (Specify)			
Do you or have you at anytime suffered from any of the following	YE S	N O	Details. (required if YES)
Skin complaints- dermatitis, Psoriasis, Eczema			
Diabetes or glandular complaints			
Headaches or Migraine			
Hypertension/ heart problems/ similar illness			
Back pains / Back injury or problems			
Jaundice / Hepatitis			
Epilepsy or fainting attacks			
Pleurisy /Bronchitis / Pneumonia			
Asthma			
Infections - ear / sore throat			
Psychiatric illness - Mental disorder/ depression etc			
At present are you having any injections/medications	YE S	N O	Details (if YES)
Are you under any treatment of any kind of condition?	YE S		
Have you had any major operations			
Physical Disabilities?			
How much time have you taken off work in the last 5 years due to illness?.			
Please state any other information about your health which may affect your work			

If you do not have vaccination information , please provide details of where we can request them below.

I certify the above information is correct and hereby give permission to **Care On Call Nursing Agency** to request a further report from my GP/ Occupational Health/ Hospital for clarification if required and for my health report.

GP /Occupational health/ Hospital \_\_\_\_\_

Address \_\_\_\_\_

Tel: \_\_\_\_\_ Mobile \_\_\_\_\_

Email address: \_\_\_\_\_

\_\_\_\_\_  
Signed (Applicant) \_\_\_\_\_

## WORK PREFERENCE

**Please specify the kind of Care work are you interested in? (tick all that apply)**

NHS \_\_\_\_\_ PRIVATE HOSPITAL \_\_\_\_\_ NURSING HOME \_\_\_\_\_

RESIDENTIAL HOME: \_\_\_\_\_ OTHERS \_\_\_\_\_

(Please specify) SHORT TERM \_\_\_\_\_ LONG TERM \_\_\_\_\_

\_\_\_\_\_

**Please indicate when you would like to work. Please tick all relevant boxes.**

### **DAILY.**

PART-TIME \_\_\_\_\_ FULL-TIME \_\_\_\_\_ BANK HOLIDAYS \_\_\_\_\_

EVENINGS (M-F) \_\_\_\_\_ DAYS (M-F) \_\_\_\_\_ NIGHTS (M-F) \_\_\_\_\_

EVENINGS (SAT-SUN) \_\_\_\_\_ DAYS (SAT-SUN) \_\_\_\_\_ NIGHTS (SAT-SUN) \_\_\_\_\_

### **AVAILABILITY**

From when are you available to work \_\_\_\_\_ come for an interview \_\_\_\_\_

\_\_\_\_\_

Do you have any holiday booked? \_\_\_\_\_ When: \_\_\_\_\_

## REHABILITATION OF OFFENDERS ACT 1974.

Because of the nature of the work for which you are applying, this post is exempt from the provisions of section 4.2 Rehabilitation of Offenders Act 1974 (Exemption Order 1975). Applicants are therefore not, entitled to withhold information about convictions, which for other purposes are 'spent' under the provision of the Act in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action. Information provided will be kept confidential and use in relationship to the post applied for..

**Have you ever been convicted of a criminal offence?** YES.....

NO.....

If yes, please specify

---

---

---

**Do you have any spent or unspent convictions** YES NO .....

If yes please specify

---

---

---

**Have you instigated an enhanced disclosure within the last six years?** YES NO

I CONSENT TO MAGGIE HEALTH CARE CHECKING THE DETAILS I HAVE PROVIDED AGAINST THE VARIOUS DATA SOURCES TO VERIFY MY IDENTITY AND PROCESS THIS APPLICATION.. THESE DETAILS MAY BE USED TO ASSIST OTHER ORGANISATIONS, SUCH AS CRB, AND FOR IDENTITY PURPOSES.

SIGNATURE

DATED

---

### REFERENCES.

Please give the names and addresses of two of most recent employers with work addresses who is able to comment on your work ability and experience. Starting with your present to most recent employer if possible.

(A)

---

Name of Reference:

Company Name

---

Address:

---

---

---



### NEXT OF KIN

Name of Emergency contact \_\_\_\_\_  
\_\_\_\_\_  
Relationship to you: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Post code: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Work No: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Mobile No: \_\_\_\_\_ Pager: \_\_\_\_\_

### WORKING TIME REGULATIONS

I have read and understood the working time regulations and I hereby consent that the working time limit shall not apply to my assignments

Print Name \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_\_\_

### FINAL STATEMENT

I declare that the information provided on this application is true to the best of my knowledge. I have read the terms and conditions of engagement and agree to comply with the current Health and Safety at Work Act. I understand that my appointment is subject to the receipt of two satisfactory references and it subject to Enhanced CRB Disclosure. Care On Call Nursing Agency is free to make any other enquiries thy may find necessary relating to my application. I agree to respect the confidentiality of patients and clients and any other information I may have access to.

Signed \_\_\_\_\_ Date \_\_\_\_\_

### AGENCY INFORMATION. OFFICE USE

CHECKLIST		NOTES
Application		
Proof of Address	Utility bills, bank statements, others.	
Proof of identity	Passport, driving license others	

Eligibility to work	Visa, Work Permit,, passport, birth cert	
CRB Application		
PAYE Form		
2 passport photograph		
Immunisation		
Signed contract		

### **AGENCY SIGN OFF**

I certify that iMAGGIE HEALTHCARE, interviewed the above applicant in accordance with Maggie Healthcare requirements, and I am satisfied that this applicant is cleared for work

**NAME OF CONSULTANT**

\_\_\_\_\_

**SIGNATURE OF CONSULTANT**

\_\_\_\_\_

**DATE**

\_\_\_\_\_