



Care staff application form

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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? _____ YesNo _____

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 _____

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Please tick the specialities for which you have significant post-training experience. Please remember you are held accountable for any missing information.

SPECIALISM	LESS THAN 6 MONTHS	MORE THAN 6 MONTHS	1- 2 YEARS	2 YEARS +
Hospitals				
Learning Disability				
Adolescents				
Children				
Mental health				
Elderly				
Physical disability				

HEALTH DECLARATION

Have you been vaccinated or tested against the following:	YES	NO	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)			
Have you or have you at any time suffered from any of the following			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?			Details (if YES)
Are you under any treatment for any kind of condition?			
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 it 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 you are 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

When are you available to work? _____

When can you come for an interview? _____

Do you have any holidays booked? Yes NO

If yes, 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 provisions 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 used in relation to the post applied for.

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

NO.....

If yes, please specify _____

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Do you have any spent or unspent convictions? YES NO

If yes, please specify _____

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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 your most recent employers with work addresses who can comment on your work ability and experience. Starting with your present to most recent employer, if possible.

(A) _____

Name of Reference: _____ Company Name _____

Address: _____

Postcode _____ city/ town; _____ country _____

Telephone no: _____ Fax no: _____

Email address: _____ Mobile phone: _____

Start date: / / End date: / / To date _____

(B) _____

Name of Reference: _____ Company Name _____

Address: _____

Postcode _____ city/ town; _____ country _____

Telephone no: _____ Fax no: _____

Email address: _____ Mobile phone: _____

Start date: / / End date: / / To date _____

BUILDING SOCIETY /BANK DETAILS

Bank Name _____

Bank Address _____

Building Society Bank Roll _____

Holders Account Name _____

Sort Code _____ Account No _____

I authorise **MAGGIE HEALTHCARE** to pay my weekly wages into the above Bank Account, and I will notify **MAGGIE HEALTHCARE** if changes occur to my details.

Signed _____ Date _____

NEXT OF KIN

Name of Emergency contact _____

Relationship to you: _____

Address: _____

Post code: _____

Home Telephone: _____ Work No: _____

Email Address: _____

Mobile No: _____

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 is subject to Enhanced CRB Disclosure. Care On Call Nursing Agency is free to make any other enquiries they 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 photographs		
Immunisation		
Signed contract		

AGENCY SIGN OFF

I certify that **MAGGIE 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 _____