APPLICATION FORM FOR WORK

Enhance Wellbeing Healthcare Ltd. Private and Confidential

Mr /Mrs/Miss/Ms(please specify)
First Name:
Surname
Date of Birth:
National Insurance No:
Address:
Post Code:
Tel:
Mobile:
E-Mail:
Marital Status:
Next of Kin:
Relationship:
Address:
Post code:
Phone Number:
Do you have permission to work in the UK
Do you have a valid passport?
Do you have a valid work permit?
Mobility
Do you drive
Do you hold a full UK driving licence?

EMPLOYMENT HISTORY OR WORK EXPERIENCE

Please record all employment in the past 5 years, including current employment by other agencies, and any other relevant experience gained within the health and social care field. Please start with the most recent one.

Employer Name Address and Tel:	From	To	Position held and Responsibilities & Duties	Reason for leaving

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EDUCATION/TRAINING AND QUALIFICATIONS

School/College	From-To	Qualification	Grade/Result

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Relevant Training	**YES/NO**	**Qualification**	**Date complete- Certificate obtained.**
Health and Safety			
Manual Handling			
Basic Food Hygiene			
First Aid			
Medication			
NVQs Level (specify which)			
Others (specify)			

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TRAINING AND WORK PREFERENCE

In order to assist us in finding a suitable work for you, please place a tick next to all specialties of which you have experience and are confident to carry out duties required.

Likewise, please put a tick on the NVQ training that you are interested in competing.

WORK PREFERENCE:

Field	Full Time	Part Time	Temporary
Hospitals			
Nursing Homes			
Residential Homes			
Learning Disability			
Mental Health			
Children			
Live – In Care			

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Day Care			

REFERENCES

1. **From your most recent employer (of at least 3 months duration which must correspond with your employment history.**

Name of Employer……
Address of Employer………
………

Telephone Number………

E-Mail Address………

FAX Number……

2. **From your Employers in the last 3 years:**

Name of Employer……
Address of Employer

Telephone Number………

E-Mail Address………

FAX Number……

3. **From a health care or Social Care professional who is not your relative and is able to supply a character Reference of your personal personality and professional profile.**

Name of Employer……
Address of Employer………
………

Telephone Number………

E-Mail Address………

FAX Number……

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HELATH DECLARATION

Please be advised that this section is compulsory and relate to Health Declaration and MUST be completed.

Occupational Health Assessment	YES	NO	Details
Are you in good health?			
How much time have you lost from work due to illness in the last five year?			
Have you ever been treated in hospital for serious illness or surgery ?Please give dates			
Have you been treated in hospital during the last 12 months?			
Do you have any physical disabilities that could affect your ability to carry out your assignment?			
Have you ever left, been retired or denied a job on health ground?			
Have you ever been denied a driving licence on health grounds?			
Are you a registered disabled person?			
Have you got any disability related to your physical or mental health?			
Have you ever suffered from any mental illness, psychological or psychiatric problems?			
Do you get discomfort or pain in chest or shortness of breath on exercise?			
Have you ever had any problems with your joints, including pain, swelling or stiffness?			
Do you have any difficulty in moving rapidly over shot distance?			
Would you have difficulty looking over either shoulder?			
Do you have any difficulty with your eyesight which is not connected by glasses or contact lenses?			
Have you any problems working with Visual Display Units?			
Do you have any difficulty hearing normal conversation?			
Are you taking any medication that makes you dizzy or drowsy?			
Do you have a medical condition affected by changing sleeping patterns or effecting day time sleep?			
Have you suffered from any alcohol or drug related illness or had an alcohol or drug problem?			
Are you having or awaiting any treatment at the moment?			
What is the date of your last chest X-ray?			
Are you receiving Medicines, Pills or Tablets from a doctor or on prescription?			
Have you ever suffered from any of the following?			
Heart Problems/Circulatory illness/Hypertension			

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High or Low Blood Pressure			
Diabetes			
Asthma/Hay Fever			
Bronchitis/Pneumonia/Pleurisy			
Tuberculosis			
Epilepsy/Fainting Attacks/Blackouts/Fits/Sudden Collapse			
Headaches/Migraine			
Dermatitis/Skin Sensitivity/Psoriasis/ Eczema/Allergies			
Psychiatric illness/Anxiety/Depression			
Back Injury/Back Problems/Back Pains			
Recurrent Infections e.g. Sore Throats/ Ear Infection/Eye Infections			
Hepatitis/Jaundice			

Have you ever been Vaccinated, Immunized or Tested for / against any of the following?	**YES**	**NO**	**Details**
Tuberculosis incl BCG, Head , Monteux or Tine			
Rubella (German Measles)			
Poliomyelitis			
Hepatitis B			
Hepatitis B Antibodies; if so, state Date and result			
HIV			
Tetanus			
Typhoid			
Any Other			
DOCTORS INFORMATION : GP NAME: Address; Postcode Phone No:			

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CARE/SUPPORT ASSISTANT ABILITY SCHEDULE

Please indicate yes/No in the areas you have had previous experience.

Personal hygiene		**Care Duties**	
Bath/shower/strip wash	YES/NO	Pressure area care	YES/NO
Bed bath	YES/NO	Simple dressing procedure	YES/NO
Use of bath aids	YES/NO	Assisting with medication	YES/NO
Shaving	YES/NO	Terminal Care	YES/NO
Mouth care (including dentures)	YES/NO		
Care of hair	YES/NO	**Practical tasks**	
Care of feet (exc.toe nails)	YES/NO	Light house work	YES/NO

Care of finger nails	YES/NO	Washing personal laundry	YES/NO
Dressing/undressing	YES/NO	Shopping	YES/NO
		Bed making/changing bed linen	YES/NO
Toileting		Collecting benefits	YES/NO
Continence Care	YES/NO		
Bedpans/commodes etc.	YES/NO	**Admin. Abilities**	YES/NO
Changing a catheter bag	YES/NO	Confidentiality	YES/NO
Empting catheter bag	YES/NO	Report writing	YES/NO
		Recording instructions from GP/District Nurse and other professionals	YES/NO
Mobility		Observing/recording	
Manoeuvrings and handling course	YES/NO	Changes in clients condition	
Use of hoists -manual and electronic	YES/NO	**Previous experience**	
Use of walking aids	YES/NO	Private house	YES/NO
		Nursing /Residential home	YES/NO
		Hospitals/ Day Centres	YES/NO

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EQUAL OPPORTUNITIES MONITORING

Employees are therefore treated the same irrespective of race, ethnic origin, disability, age and gender. Hence, we request all candidates to provide below information in order to monitor the effectiveness of Enhance Wellbeing Healthcare policy.

Name ………

Age Group 16- 20 ☐ 21-35 ☐ 36 -50 ☐ 50 ☐

Registered disability ☐

Unregistered disability ☐

No disability ☐

Please tick appropriate box which best describes your Ethnic Origin

White European ☐

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White Other ☐

Black African ☐

Black Caribbean ☐

Black Other ☐

Indian ☐

Pakistani ☐

Chinese ☐

Others ☐

How did you hear about the post you are applying for?

Are you related or do you know any member of staff at Enhance Wellbeing Healthcare Ltd.

REHABILITATION OF OFENDERS ACT 1974

Please be advised that you are not entitled to withhold any information about convictions, which are regarded as spent under the ACT: This is due to the nature of the work involved renders the post exempt from sec.4 (2) of the Act in accordance with the Rehabilitation of Offenders Act 974 (Exceptions) Order 1975.

You are therefore required to give details of all convictions and cautions including "spent" conventions. Any information, which you may give, will be strictly confidential and will be considered only in relation to this or a similar position for which you may be considered with Enhance Wellbeing Healthcare Enhance Wellbeing Healthcare Ltd.

Have you ever been convicted of a criminal offence? **YES / NO**

If **yes,** please give details of all convictions and cautions, including spent convictions and cautions: (Please use a separate sheet if necessary)

……….

…….

You are required to complete the Criminal Records Bureau's (DBS) Disclosure form. All health and Social Care professionals registered with Enhance Wellbeing Healthcare Ltd are subject to this disclosure process in the interests of all parties concerned.

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DECLARATION

I declare that:

All information given is true in every respect. I have read and understood the Terms and Conditions and I agree to comply with the current Health and Safety at Work Act.

I have never been charged with, or convicted of an offence under any legislation dealing with Residential Care or any offence involving dishonesty or violence.

I have been issued with a staff handbook and informed of the importance of reading and understanding it.

Signature…………………………………….   Date …/……………/……………

DOCUMENTS RQUIRED FOR REGISTRATION

- **VALID WORK PERMIT**

  (For student-Student Visa)

- **PASSPORT**

  (Or other current Home Office Document authorizing you to work in United Kingdom)

- **NATIONAL INSURANCE (NI) CARD**

  (Or p45, or p60 or letter confirming you have applied for NI)

- **PROOF OF ADRESS**

  (Such as driving Licence, Utility Bill, bank statements with your name and address.

- **2 CURRENT PASSPORT SIZE PHOTOGRAPHS**

-

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- **CRIMINAL RECORDS BUREAU CERTIFICATE (DBS)**

  (You are required to apply with us).

- **TRAINING CERTICATES**

  (Such as, Basic food hygiene, Moving &Handling, and Health and Safety etc.. You are required to complete all Mandatory training with Enhance Wellbeing Healthcare

BANK DETAILS

NAME…………………………………………………………

ACCOUNT NAME……………………………………………………..

BANK NAME……………………………………………………..

BANK ADDRESS……………………………….

ACCOUNT NUMBER…………………………………..

SORT CODE…………………………………………………

Signature ………………………………………………………………… Date……/……… /……….

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