

Please attach 2 passport photographs, writing your name on the back



TELFORD
Broadway House
2 Haygate Road
Wellington
Telford
TF1 1QA

**CONFIDENTIAL APPLICATION
FOR MEMBERSHIP**

Please print carefully in black ink and return your completed application form to the above address

POSITION APPLIED
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SECTION 1 – PERSONAL DETAILS

Title : Surname :
Previous Surname (if any) : Maiden Name :
Forenames in full :
Address :
Postcode :

Tel No's – Home: Work: Mobile :

Date of Birth : Age : National Insurance Number :

Do you hold a current CRB check YES NO Standard or Enhanced Date:

Do you hold a current driving license? YES NO

Details of any endorsements, if any :

SECTION 2 – TELL US ABOUT YOUR PRACTICAL EXPERIENCE AND QUALIFICATIONS / COURSES

Please give relevant details and dates of any training or courses you have attended (e.g. First Aid, NVQ, Food Hygiene, Manual handling etc)

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To assist us in finding, suitable work for you please tick all the care tasks in which you are experienced :

Personal Hygiene

- Bath/shower/Strip wash
- Bed Bath
- Use of bath aids
- General personal care

Mobility

- Moving & Handling course
- Use of hoists (man/elect.)
- Use of walking aids
- Moving & handling clients

General

- Assisting with client personal shopping
- Part Taking in Leisure activities
- Epilepsy Trained
- Control and Restraint Trained

SECTION 2 – TELL US ABOUT YOUR QUALIFICATIONS

Please give relevant details and dates of any training or courses you have attended :

Location of Training	Dates of Training	Qualifications
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SECTION 3 – EMPLOYMENT HISTORY

Please print details of all your employment for a period of at least 5 years, in reverse date order, starting with your present or last position first.

Name and address of previous employer leaving	Position held	Type of Organization	Date From	Date To	Reason for leaving
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Please briefly describe your duties

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SECTION 4 – REHABILITATION OF OFFENDERS ACT 1974

By virtue of the Rehabilitation of Offenders Act 1974 (Exemptions) (Amendments) Order 1986, the provisions of section 4.2 of the Rehabilitation of Offenders Act 1974 do not apply to any employment which is concerned with the provision of health services and which is of such a kind as to enable the holder to have access to persons in receipt of such services in the course of his/her normal duties. Your answer to the following questions should include any ' spent' convictions. This may or may not affect your application.

1. Do you have any convictions or cautions? Please write your answer:

2. Are you currently the subject of any criminal proceedings (for example charges or summoned but not ye dealt with) or any police investigation? Please write your answer :

If your answer to either of the above questions is YES, please give details below (continue on a separate sheet is necessary)

Table with 4 columns: Date, Nature of convictions, caution, charge, allegation or investigation, Court, Result

All applicants are required to have a police check.

Do you agree that such checks may be made concerning you if required? [] YES [] NO

SECTION 5 – REFERENCES

Please give the names of two people, including your present or most recent employer, whom we may approach for a nursing reference (not relatives or friends). Please provide work and not home addresses.

Can we approach your referees before your interview? (1) [] YES [] NO (2) [] YES [] NO

(1) Name: Position: Address:

Post Code: Telephone Number : Known me for years

(2) Name: Position: Address:

Post Code: Telephone Number : Known me for years

SECTION 6 – DECLARATION

The information that I have given in this application form is, to the best of my knowledge, complete and accurate in all respects. I understand that knowingly giving false information will disqualify me from membership with Primecare Staff Agency

Name: Position applied for:

Signed: Date:

CONFIDENTIAL – DECLARATION OF HEALTH

Name :

Date of Birth : Male Female Height : Weight :

General Practitioner's Name and Address or Occupational Health Department :

Post Code : Telephone Number:

Date of last medical examination: Date of last dental examination:

Have you attended hospital as either an in patient or out patient during the last 5 years? YES NO

If yes, please give details :

Are you currently taking any medication? YES NO

If yes, please give details :

Have you ever been refused life insurance or employment for health reasons? YES NO

If yes, please give details :

Have you ever left employment due to health reasons? YES NO

If yes, please give details. Please detail any disability :

Are you currently receiving any medical treatment? YES NO

If yes, please give details :

Have you ever had or currently have any problems with the following?

It is your responsibility to inform us immediately if any of the following information changes.

- | | | |
|---|------------------------------|-----------------------------|
| 1. Anxiety/Nervous or Psychiatric illness? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Excessive Weight loss/gain? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Migraine/Severe headaches/Neck pain? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Asthma/Hay Fever? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Chest infection/Conditions? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Heart/Circulation/Blood pressure/Varicose veins? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Bladder/Kidney problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Back problems including strain, causing time off work? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Fainting/Epilepsy/Blackouts? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Have you ever had or currently have any problems with the following?

It is your responsibility to inform us immediately if any of the following information changes.

- 10. Thyroid / Diabetes / Other glandular illness? YES NO
- 11. Skin disorders? YES NO
- 12. Ears / Eyes? YES NO
- 13. Blood disorders / Jaundice? YES NO
- 14. Rheumatism / Arthritis? YES NO

Have you had any of the following diseases?

- 15. Chicken Pox? YES NO
- 16. Hepatitis A, B or C? YES NO
- 17. Typhoid? YES NO
- 18. Tuberculosis? YES NO
- 19. Food poisoning? YES NO

If Yes to any of the above, please give details :
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How much time have you lost from work due to illness in the last two years? (please provide details):

Note: I declare that the above information is correct to the best of my knowledge. I understand that if further information is required from my GP/Occ Health I will be asked to give my consent:

Signed : Date :

FOR OFFICE USE ONLY

Interviewer :

Name :

Position :

Signature :

Date :

YES NO
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