Passport Photos

X 2

APPLICATION FORM
PRIVATE & CONFIDENTIAL

MR/MRS/MISS/MS (please delete as appropriate)	
FIRST NAME:	
MIDDLENAME:	
SURNAME:	
DATE OF BIRTH:	
NATIONAL INS. NO.	
ADDRESS	
POSTCODE:	
HOME TEL:	
MOBILE:	
E-MAIL:	
MARITAL STATUS:	
NEXT OF KIN:	
RELATIONSHIP:	
ADDRESS:	
POSTCODE:	
PHONE NUMBER:	
DO YOU HAVE PERMISSION TO WORK IN THE UK?	**YES / NO**
DO YOU HAVE A VALID PASSPORT?	**YES / NO**
YOU HAVE A VALID WORK PERMIT?	**YES / NO**
MOBILITY:	
DO YOU HAVE ACCESS TO A CAR WHICH CAN BE USED FOR WORK PUPROSES?	**YES / NO**
DO YOU HOLD A FULL UK DRIVING LICENCE?	**YES / NO**

QUALIFICATIONS/TRAINING

Qualifications	School/College	Grade/Result	Dates: From-To

Relevant Training/Qualifications in Healthcare		Certificates Date
Manual handling	YES/NO	
Health and safety	YES/NO	
Basic food hygiene	YES/NO	
First aid	YES/NO	
NVQ levels	YES/NO	
Others (please list)	YES/NO	

EMPLOYMENT HISTORY / 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 care industry. Please start with the most recent. **Please note that we shall obtain a reference from your LAST EMPLOYER**

Employer Name, Address & Tel no.	From	To	Position held, Duties and Responsibilities	Reason for Leaving

REFERENCES

1a) Must be 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 ……...

Fax Number……..

1b) Another of your Employers in the last 3 years:

Name of Employer……...

Address of employer…….. ……

…….
.

Telephone Number ……...…….

E-mail ……...

Fax Number……..

2) Must be a fellow health care professional who does not live with you and is able to supply a character Reference of your personal and professional profile.

Name of Employer……...

Address of employer…….. ……

…….
.

Telephone Number ……...…….

E-mail ……...

Fax Number……..

HEALTH DECLARATION

Carers/Support workers are required to complete this Health Declaration. Any positive answers will not necessarily affect your application. Please list any medical conditions (past or present) which may affect your ability to do the job.

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 years? Please provide details			
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 grounds?			
Have you ever been denied a driving licence on health grounds?			
Are you a registered disabled person?			
Have you 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 the 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 short distances?			
Would you have difficulty looking over either shoulder?			
Do you need to wear glasses or contact lenses?			
Do you have any difficulty with your eyesight which is not corrected by glasses or contact lenses?			
Have you any problems working with Visual Display Units?			
Have you any problems working in confined spaces/using lifts?			
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 affecting 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			
High or Low Blood Pressure			
Diabetes			
Asthma/Hay fever			
Bronchitis/Pneumonia/Pleurisy			
Tuberculosis			
Epilepsy/Fainting Attacks/Blackouts/Fits/Sudden Collapse			
Headaches/Migraine			
Psychiatric Illness/Anxiety/Depression			
Dermatitis/Skin Sensitivity/Psoriasis/Eczema/Allergies			
Back Injury/Back Problems/Back Pains			
Recurrent Infections e.g. Sore Throats/Ear Infections/Eye Infections			
Hepatitis/Jaundice			

Have you ever been Vaccinated, Immunized or Tested for / against any of the following?	YES/NO	DETAILS
Tuberculosis incl BCG, Heaf, Mantoux or Tine		
Rubella (German Measles)		
Poliomyelitis		
Hepatitis B		
Hepatitis B Anitbodies Date and Result		
HIV		
Tetanus		
Typhoid		
Any Other		

DOCTOR INFORMATION

GP Name:
Address:

Postcode:
Phone:

WORK PREFERENCE

To assist us in finding suitable work for you, please place a tick next to all specialties of which you have significant recent experience and are confident to carry out such duties. Please keep us informed from time to time of all developments in your career as the work we assign to you depends on accurate up to date information.

WORK PREFERENCE: (Please tick)	
Full time / Part time	
If part time, how many hours per week do you want to work...	
Home care and pop-in visits	
Hospitals Nursing/Residential Homes	
Morning / Day / Evening / Night Sleeper duty	

Live-In Care	
Please state if you are able to work as a 24-hour Residential (live-in) Carer.	*YES / NO*
If YES, would you like:	
Long…… or short ……. assignments?	
Would you accept a live-in assignment some distance from your home?	*YES / NO*
If NO, please specify preferred areas:	

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(inc. 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***		***Yes/No***
Bedpans/commodes etc.	***Yes/No***	***Admin. Abilities***	
Changing a catheter bag	***Yes/No***	*Confidentiality*	***Yes/No***
Empting catheter bag	***Yes/No***	*Report writing*	***Yes/No***
		Recording instructions from GP/DISTRICT NURSE	***Yes/No***
Mobility		*Observing/recording*	***Yes/No***
Maneuvering and handling course	***Yes/No***	*Changes in clients condition*	***Yes/No***
Use of hoists(man./elec)	***Yes/No***	***Previous exp.***	
Use of walking aids	***Yes/No***	*Private house*	***Yes/No***
		Nursing/residential home	***Yes/No***

EQUAL OPPORTUNITIES MONITORING

BFTTT Resources Inc., Ltd aims to be an equal opportunities employer. Employees are therefore put forward for work / shift irrespective of race, ethnic origin, disability, age and gender. In order to monitor the effectiveness of our policy, we request all candidates to provide the following information.

Name .....……

Age Group 16 – 20 ○ 21 – 35 ○ 36 – 50 ○ 50+ ○

Registered disability ○

Unregistered disability ○

No disability ○

Please tick appropriately which best describes your Ethnic Origin.

White European ○

White Other ○

Black African ○

Black Caribbean ○

Black Other ○

Indian ○

Pakistani ○

Chinese ○

Other ○

How did you hear about the post?

……

Are you related or do you know any member of staff at **BFTTT Resources Inc., Ltd**.

……

REHABILITATION OF EX- OFFENDERS ACT 1974

You are advised that you are not entitled to withhold 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' convictions. Any in formation, 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* ***BFTTT Resources Inc., Ltd****.*

Have you ever been convicted of a criminal offence? ***YES I 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 Disclosure and Barring Service (DBS) Disclosure form. All health professionals registered with Disclosure and Barring Service are subject to this disclosure process in the interests of all parties concerned.

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
(ii) 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.
(iii) been issued with a staff handbook and informed of the importance of reading and understanding it.

Signature. ……. Date……..……

Disclosure and Barring Service – ENHANCED DISCLOSURE

Forenames ..... Surname .....

I understand that before I can commence work with **BFTTT Resources Inc., Ltd**, I will need to be in possession of a DBS Enhanced Disclosure.

Signature..... Date ……. /……. /…….

DOCUMENTS NEEDED FOR REGISTRATION

- **VALID WORK PERMIT**
(Or if Student, College ID and Student Visa,)

- **BRITISH PASSPORT** (or other current Home Office Document authorizing you to work in UK)

- **NATIONAL INSURANCE (NI) CARD**
(Or P45 or P60 or letter confirming you have applied for Ni

- **PROOF OF ADDRESS**
E.g. Driving Licence, Utility Bill, or any formal letter with your name and address

- **2 CURRENT PASSPORT SIZE PHOTOGRAPHS**

- **Disclosure and Barring Service (DBS)** you apply with us.

- **TRAINING CERTIFICATES**, e.g. Moving & Handling, Basic Aid etc. If you do not have the certificates we can provide training

RIGHT TO WORK ENQUIRY AGREEMENT

I agree and give permission for BFTTT Resources Inc., Ltd to take appropriate action and contact the appropriate authorities as a part of their effort to validate my right to work in the UK.

Print Name: Signature: Date:

CONFIDENTIALITY AGREEMENT

I agree that during the time I am engaged by **BFTTT Resources Inc., 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 **BFTTT Resources Inc., Ltd** all such information, and never use it in other than for the benefit of Health First Medical Staffing Ltd.

Print name: Signature Date

BFTTT Resources Inc., Ltd DECLARATION

If you provide false or misleading information to support your application it will disqualify you from being engaged as an employee BFTTT Resources Inc., Ltd. If it is found that you provided false or misleading information to support your application after or during employment, BFTTT Resources Inc., Ltd has the right to terminate your contract on this basis.

I hereby declare that I understand and complied with the requirements laid down in the application and I agree that the information given on this form maybe used to obtain DBS checks on me from the policy authorities.

Name print Signature Date:

BANK DETAILS

Name……

Account Name……...

Bank Name……

Bank Address……

Account Number……..

Sort Code……

Signature……**Date**……...