

# APPLICATION FORM



## Excell Health Care

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Position Applied For

## PERSONAL DETAILS



Title: Mr  Miss  Mrs  Ms  Other

Surname:

First Name:

D.O.B:  Marital Status:

Nationality:  NI Number:

Address:

Post Code:

Tel:  Mobile No:

Email:

## PASSPORT DETAILS

Passport Number:  Place of Issue:

Issue Date:  Expiry Date:

Visa Expiry Date:  Visa Status:

If Student, please provide course details:

## NEXT OF KIN

Name:

Relationship:

Address:

Tel:  Mobile No:

Email:

## EDUCATIONAL QUALIFICATIONS

Place of Study	Qualifications	Date Qualified

*\* Use and additional sheet if necessary*

## TRAININGS

Course Name	Date Attended	Expiry Date	Details (e.g. Provider)
<ul style="list-style-type: none"> <li>* Moving &amp; Handling Theory</li> <li>* Manual Handling Practical</li> <li>* Safeguarding Vulnerable Adults                             <ul style="list-style-type: none"> <li>* Fire Safety</li> <li>* Health &amp; Safety</li> </ul> </li> <li>* COSHH and RIDDOR                             <ul style="list-style-type: none"> <li>* Infection Control</li> </ul> </li> <li>Person Centred Care                             <ul style="list-style-type: none"> <li>* Food &amp; Hygiene</li> <li>* Dementia Care</li> </ul> </li> <li>Medication Management / Administration (for RNs*)</li> <li>Life Support</li> <li>First AID</li> </ul> <p><i>Use and additional sheet if necessary</i></p> <p><i>* Mandatory Trainings</i></p>			

## WORK EXPERIENCE

Date From	Date To	Employer's Name & Address	Job Title	Duties

*\* Use and additional sheet if necessary*

## PROFESSIONAL REGISTRATION DETAILS

*\*This is mandatory for Nurses*

Registration Body (e.g. NMC)	Registration No (e.g. NMC reg. No.)	Expiry Date

Are you a member of any union (e.g. RCN, Unison etc.)      Yes       No

If yes, please give details

## EMPLOYMENT REFERENCES

### **Reference 1**      *\* Please provide a minimum of 2 references*

Employer:

Name:       Position:

Address:

Post Code:

Tel No:       Fax:

Email ID:

Can we contact this referee prior to the interview?      Yes       NO

### **Reference 2**

Employer:

Name:       Position:

Address:

Post Code:

Tel No:       Fax:

Email ID:

Can we contact this referee prior to the interview?      Yes       NO

### **Reference 3**

Employer:

Name:       Position:

Address:

Post Code:

Tel No:       Fax:

Email ID:

Can we contact this referee prior to the interview?      Yes       NO

## Equal Opportunity Monitoring Form

The information on this form will be used in fatal confidence and accordance with current data protection legislation. It will help to ensure that the company properly monitors and confirms with its policies relating to equality of opportunity. Information will be used for monitoring only. Our commitment aims to allow our staff to develop their skills and realize their maximum potential as individuals without any wish on the part of the company to limit their opportunity.

PLEASE TICK THE RELEVANT BOX

White <input type="checkbox"/>	Mixed <input type="checkbox"/>	Asian <input type="checkbox"/>	Black <input type="checkbox"/>	Chinese <input type="checkbox"/>	Other <input type="text"/>
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>			

Please indicate your age range by ticking one of the boxes below:

16-21 <input type="checkbox"/>	22-25 <input type="checkbox"/>	26-30 <input type="checkbox"/>	31-35 <input type="checkbox"/>	36-40 <input type="checkbox"/>	41-50 <input type="checkbox"/>	51-55 <input type="checkbox"/>	Above 55 <input type="checkbox"/>
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Do you consider yourself to have a disability of some kind? Yes  No

If Yes, Please give Details

## Protection of Children and Vulnerable Adults Declaration

Has any Social Service Department or Police Service ever conducted an enquiry or investigation into any allegations or that you may pose an actual or potential risk to children or vulnerable adults? Yes  No

Have you ever been convicted of any offence relating to children or vulnerable adults? Yes  No

Have you ever been the subject of any disciplinary procedure or been asked to leave employment or voluntary activity due to inappropriate behaviour towards a child or vulnerable adult? Yes  No

If you have answered 'YES' to any of these questions above, please give details.

## Rehabilitation of Offenders

Because of the nature of the work for which you are applying, this post is exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974, by virtue of the 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 and in the event of employment any failure to disclose such convictions could result in dismissal or disciplinary action by the employer. All Successful candidates will be required to obtain an enhanced disclosure report from the Disclosure and Barring Service. Have you ever been convicted of a criminal offence, or been subject to any confidential discharge, bind overs or caution.

If you have answered 'YES' above, please give details. Yes  No

\* Any information contained in the above forms will be treated in confidence. Failure to disclose any relevant information or providing false or inaccurate information may be regarded as a breach of any subsequent contract of employment, resulting in disciplinary action and/or dismissal.

## Health Check Questionnaire

(Optional/to be filled upon selection)

GP Name & Contact Details:



**Please answer all the following questions by giving relevant details**

1) Have you ever suffered from any of the following:

- a) Depression, anxiety state, nervous illness or breakdown Yes  No
- b) Epilepsy or disease of the nervous system Yes  No
- c) Ailment of lungs or chest Yes  No
- d) Spinal problem (backache) Yes  No
- e) Arthritis, Rheumatism or Gout etc Yes  No
- f) Any heart or circulatory, including blood problems Yes  No
- g) Illness of the kidneys, bladder, liver or glans Yes  No
- h) Diabetes Yes  No
- i) Skin disorder Yes  No

**If Yes, Please give Details**

2) Are you presently taking medication or undergoing treatment? Yes  No

**If Yes, Please give details:**

3) What is your average consumption, if any Alcohol  Tobacco

4) Are you a registered disabled person? Yes  No

5) Details of any industrial disablement benefit received:

6) How many working days have you been absent from working during the last 12 months?

7) Are you now pregnant? Yes  No

8) Additional details: (if necessary):

How Did you hear about us?

## Declaration

I confirm that the information given within this form is true and accurate. I hereby give consent for this information being used for personnel administration and business purposes.

Name

Signature (should be inside the box)

Date




## Office Use Only

- |                                              |                                               |                                             |                                                  |
|----------------------------------------------|-----------------------------------------------|---------------------------------------------|--------------------------------------------------|
| Address & Postcode: <input type="checkbox"/> | Telephone & Email: <input type="checkbox"/>   | Qualification Det: <input type="checkbox"/> | If Student, Course Det: <input type="checkbox"/> |
| DBS: <input type="checkbox"/>                | Passport & Visa Det: <input type="checkbox"/> | NI Number: <input type="checkbox"/>         | NMC Registration Det: <input type="checkbox"/>   |
| References: <input type="checkbox"/>         | Mandatory Trainings: <input type="checkbox"/> | Next Of Kin: <input type="checkbox"/>       | Signature: <input type="checkbox"/>              |

Any Other Details:

Checked By

Signature

Date: