Assurance Care Services

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Licensed by ***CQC***

APPLICATION FORM

POSITION APPLIED FOR: _____

A. PERSONAL INFORMATION.

Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Surname:_____ Forenames:_____

Maiden Name:_____ Date of Birth:_____

Address:_____

_____ Post Code: _____

Telephone number:_____ Mobile:_____

Email:_____

Nationality:_____ NI Number:_____

Do you require a work permit? Yes ☐ No ☐

Do you hold a valid UK driving license? Yes ☐ No ☐

B. NEXT OF KIN DETAILS

Name:_____ Relationship:_____

Address: _____

_____ Post Code:_____

Telephone number: _____

C. EDUCATION AND QUALIFICATIONS.

Please provide details of Schools/Colleges/Universities attended and qualifications gained (most recent first). Please also include details of any registrations to Professional Regulatory Councils, for example, GSCC or NMC.

Name and Address of School/ College/University.	Dates from:	To:	Qualification

D. TRAINING AND DEVELOPMENT.
Please provide details of training and development courses attended and any certificates awarded, for example Health and Safety Certificate.

Course Title	Date	Certificate Held

E. EMPLOYMENT HISTORY.

Please provide information (most recent first) of the organisation/s you have been employed by either on a full-time, part-time or temporary basis. Include any voluntary or unpaid work undertaken.

Employer Name and Address	Dates of employment	Job title	Reason for leaving

F. PERSONAL STATEMENT.
Please explain how you are suitable for the position you are applying for.

Personal Statement

G. REHABILITATION OF OFFENDERS ACT.
The post for which you are applying is exempt from section 4.2 of The Rehabilitation of Offenders Act 1974. You are required to disclose information concerning convictions which for other purposes are "spent under the provisions of the Act. Any information given in this respect will be completely confidential and will be considered only in relation to this application. Failure to disclose any such convictions could result in dismissal or disciplinary action being taken against you, should your application be successful.

I do have a criminal conviction and/or pending prosecutions ☐
Please provide details: _____

_____

I do not have a criminal record and/or any pending prosecutions ☐

I declare the details given are correct.

Signature:_____Date: _____

H. REFERENCES.
As part of our recruitment and selection process please provide us with the names and addresses of people able to provide professional references, covering the last 3 years.

Referee Name	Organisation name and address	Position held and contact details
1.		Tel: Fax:
2.		Tel: Fax:
3.		Tel: Fax:

May we approach your above named referees prior to interview? Yes ☐ No ☐

I declare that the information provided within this application is accurate and true to the best of my knowledge.

Signature: _____ Date: _____

HEALTH QUESTIONNAIRE
(CONFIDENTIAL)

PERSONAL INFORMATION.

Position applied for: _____

Full Name: _____ Date of Birth: _____

Gender: _____

Address: _____

_____

Post Code: _____

Telephone number: _____Mobile: _____

HEALTH INFORMATION.

1. What is your height?_____2. Your current weight?_____

3. Do you consider yourself to be in good health?_____

4. How many days sick leave have you taken within last 12 months? _____days.

5. Are you currently taking any medication? _____

6. When did you have:-

a) Last physical examination_____b) Chest X-ray?_____

7. Please provide details of all vaccinations (Including Hepatitis B, Rubella, BCG etc):-

Vaccination	Date Received	Duration of immunity

8. Please answer the following questions. Where the answer is yes, please provide additional information, including relevant dates and state duration of the illness/condition.

Condition	Yes	No	Additional Information
Allergies			
Asthma, Hay fever			
Bronchitis, Pneumonia			
Tuberculosis			
Diabetes			
High blood pressure			
Mental illness			
Nervous breakdown			
Depression, anxiety			
Migraine, headaches			
Blackouts, Fits, Epilepsy			
Prolonged back pain			
Disc trouble, Hernia			
Joint problems			
Heart condition			
Stomach or intestinal disorders			
Visual impairment			
Hearing impairment			
Physical disability			
Learning disability			
Other (Specify)			

Name of GP: _____

Address: _____

_____Post Code:_____

Telephone number: _____Fax: _____

I can confirm that information provided within the health questionnaire to my knowledge is true and accurate account.

Signature:_____Date:_____

I give my consent ☐

I do not give my consent ☐

for Christ The King Residential Care Homes Ltd, to approach my medical practitioner to request a letter of health clearance for employment purposes.

Signature: _____Date:_____