Nikee HealthCare Services

Passport Photos

X 2

APPLICATION FORM
PRIVATE & CONFIDENTIAL

PLEASE USE A BLACK PEN TO COMPLETE ALL SECTION

MR/MRS/ MISS/ MS (please delete as appropriate)	
FIRST NAME:	
MIDDLE NAME:	
SURNAME:	
DATE OF BIRTH:	
NATIONAL INS. NO.	
DBS REFERENCE 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 PURPOSES?	**YES / NO**

DO YOU HOLD A FULL UK DRIVING LICENCE?	YES / NO

DBS CERTIFICATE NUMBER / _____

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	
Medication competency	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 field. 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:	

Night Worker Declaration

I certify that all the answers given above are true to the best of my knowledge and belief. And I am fit to take a night shift. I understand that no medical details will be divulged without my permission to any person outside Occupational Health, but an opinion about my fitness for night work will be issued to management.

Signed: Date:

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

Nikee HealthCare Services is an equal opportunity 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 Nikee HealthCare Services Ltd

……

Opting out of the 48 hour week

You can choose to work more than 48 hours a week on average if you're over 18. This is called 'opting out'.

Your employer can ask you to opt out, but you can't be sacked or treated unfairly for refusing to do so.

You can opt out for a certain period or indefinitely. It must be voluntary and in writing.

Opt-out agreement:

I [ ] agree that I may work for more than an average of 48 hours a week. If I change my mind, I will give Nikee HealthCare Services [amount of time - up to 3 months'] notice in writing to end this agreement.

Signed…… Dated……

REHABILITATION OF 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 Reliable care services.*

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 Nikee HealthCare Services Ltd 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) I have 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 Nikee HealthCare Services LTD,
I will need to be in possession of a DBS Enhanced Disclosure.

5 YEARS DETAILS OF PAST LIVED ADDRESS IS NEEDED
(IF YOU DON'T HAVE A CURENT DBS OR YOU NEED TO DO ONE)

Signature..... Date ……. /……. /…….

DOCUMENTS NEEDED FOR REGISTRATION

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

• Do you require a work permit? Yes /No

• 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 CERTIFICATE (DBS) you can apply with us, if you don't have one.

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

BANK DETAILS

Name……

Account Name……...

Bank Name……

Bank Address……

Account Number……..

Sort Code……

Signature……**Date**……...