8B Station Road | New Milton | BH25 6JU.
Tel:01425204669 | Mob: 07474719869
Email: info@relycare.co.uk | Web: www.relycare.co.uk

CARE STAFF APPLICATION FORM

Please use CAPITAL LETTERS throughout.

PERSONAL DETAILS

Title:________________________ Surname:________________________
Forename:________________________ Maiden Name:________________________
Middle Maiden:________________________ Marital Status:________________________
Date of Birth:________________________ Male:________________ Female:………...________
Age:________________________ National Insurance:________________________
Address: ____

____

____

____

City / Town:________________________ Country:________________________
Postcode:________________________ Home Telephone:________________________
Mobile phone:________________________ Work Phone:________________________
Page No:________________________ Email Address:________________________
Preferred Contact Method:____________ Are you willing to expect morning calls? __________
Are you willing to expect late Night calls? Yes ( ) No ( )

VARIOUS INFORMATION

Work status:____________ Passport Number:__________ Exp. date:_____ / _____ / __________
Nationality:________________________ Birth certificate No:________________________
Home Office Letter ref:________________ Have Work Permit?____Yes__________No__________
Work Permit Type:________________________ Expiration Date:________________________
Name of college/university (if student): ________________________________
Have your own transport?______________ Type of Transport?________________________
Have you a driving license?______________ If yes any endorsement?____________________
Religion:____________________ Ethnic Origin:________________________________
Children under 18 years?______________ Ages:________________________________
Do you smoke? Yes__________No__________ Registered Disabled?__Yes__________No__________
Registration No: ____
Give details of hobbies/leisure activities:________________________________

____

____

____

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PROFESSIONAL EDUCATION AND TRANING.

Please list any Training / Course / healthcare qualifications you have and when you gained them:

Qualification:	School / College University.	Dates
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

Please tick the specialities of which you have significant, post training experience. Please remember you have held accountable for any missing information.

SPCIALISM	LESS THAN 6 MONTHS	MORE THAN 6 MONTHS	1- 2 YEARS	2 YEARS +
Hospitals				
Learning Disability				
Adolescents				
Children				
Mental health				
Elderly				
Physical disability				
HIV				
Residential Homes				
Nursing homes				

EMPLOYMENT HISTORY

Please give details of your past 5 years of continuous work history giving reasons/s for any breaks in employment

From:________/______/______To:____/______/______Employer:______________________________
Employer's Address: ____
____
____
____
Telephone:______________________________Main contact:___________________________
Post Title:______________________________Grade:_________________________________
Full time or part-time:______________________Salary:________________________________
Main responsibilities:____
____
____

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Reason for leaving: ______________________________

From:________/______/______To:___/______/______Employer:______________________
Employer's Address: ______________________________

Telephone:______________________Main contact:______________________
Post Title:______________________Grade:______________________
Full time or part-time:______________________Salary:______________________
Main responsibilities:______________________________

Reason for leaving: ______________________________

From:________/______/______To:___/______/______Employer:______________________
Employer's Address: ______________________________

Telephone:______________________Main contact:______________________
Post Title:______________________Grade:______________________
Full time or part-time:______________________Salary:______________________
Main responsibilities:______________________________

Reason for leaving: ______________________________

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From:________/______/______To:___/______/______Employer:____________________
Employer's Address: ____

Telephone:____________________________Main contact:________________________
Post Title:_____________________________Grade:____________________________
Full time or part-time:_____________________Salary:____________________________
Main responsibilities:____

Reason for leaving: ____

From:________/______/______To:___/______/______Employer:____________________
Employer's Address: ____

Telephone:____________________________Main contact:________________________
Post Title:_____________________________Grade:____________________________
Full time or part-time:_____________________Salary:____________________________
Main responsibilities:____

Reason for leaving: ____

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HEALTH DECLARATION

Have you been vaccinated or tested against the following:	YES	NO	DETAILS (Plus dates if YES)
Hepatitis B			
HIV			
Tetanus			
Poliomyelitis			
Typhoid			
Rubella (German Measles)			
Tuberculosis and BCG			
Hepatitis B Antibodies			
Mantoux, tine or Heaf			
Varicella			
Last X-ray			
Others (Specify)			
Do you or have you at anytime suffered from any of the following	YES	NO	Details. (required if YES)
Skin complaints- dermatitis, Psoriasis, Eczema			
Diabetes or glandular complaints			
Headaches or Migraine			
Hypertension/ heart problems/ similar illness			
Back pains / Back injury or problems			
Jaundice / Hepatitis			
Epilepsy or fainting attacks			
Pleurisy /Bronchitis / Pneumonia			
Asthma			
Infections - ear / sore throat			
Psychiatric illness - Mental disorder/ depression etc			
At present are you having any injections/medications	YES	NO	Details (if YES)
Are you under any treatment of any kind of condition?	YES		
Have you had any major operations			
Physical Disabilities?			
How much time have you taken off work in the last 5 years due to illness?.			
Please state any other information about your health which may affect your work			
If you do not have vaccination information , please provide details of where we can request them below.			

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I certify the above information is correct and hereby give permission to RELY CARE LIMITED to request a further report from my GP/ Occupational Health/ Hospital for clarification if required and for my health report

GP /Occupational health/ Hospital: ____________________
Address: ____________________
____
Tel:____________________Mobile: ____________________
Email address: ____________________

Signed (Applicant): ____________________

WORK PREFERENCE

What kind of Nursing Work are you interested in? (tick all that apply)

NHS:__________PRIVATE HOSPITAL:__________NURSING HOME:__________

RESIDENTAL HOME:__________OTHERS:__________

(Please specify) SHORT TERM:__________LONG TERM:__________

Please indicate when you would like to work. Please tick all relevant boxes.

DAILY

PART-TIME:__________FULL-TIME:__________BANK HOLIDAYS:__________
EVENINGS (M-F):__________DAYS (M-F):__________NIGHTS (M-F):__________
EVENINGS (SAT-SUN) DAYS (SAT-SUN):__________NIGHTS (SAT-SUN):__________

AVALIBILITY
From when are you available to work:__________Come for an interview:__________
Do you have any holiday booked?__________When:__________

REHABILITATION OF OFFENDERS ACT 1974.

Because of the nature of the work for which you are applying, this post is exempt from the provisions of section 4.2 Rehabilitation of Offenders Act 1974 (Exemption Order 1975). Applicants are therefore, entitled to withhold information about convictions, which for other purposes are 'spent' under the provision of the Act in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action. Information provided will be kept confidential and use in relationship to the post applied for.

Have you ever been convicted of a criminal offence? YES……………NO…………… .
If yes, please specify: ______________________________
____
____

Do you have any spent or unspent convictions: ______ YES ______ NO ______
If yes please specify: ______________________________
____

Have you instigated an enhanced disclosure within the last six years? YES NO

I CONSENT TO MY NURSING AGENCY CHECKING THE DETAILS I HAVE PROVIDED AGAINST THE VARIOUS DATA SOURCES IN ORDER TO VERIFY MY INDENTITY AND PROCESS THIS APPLICATION. THESE DETAILS MAYBE USED TO ASSIST OTHER ORGANISATION SUCH AS CRB, NMC IN IDENTITY PURPOSES.

SIGNATURE ______________________________ DATED ______________

REFERENCES.

Please give the names and addresses of two of most recent employers with work addresses who is able to comment on your work ability and experience. starting with your present to most recent employer if possible.

(A)

Name of Reference: ______________________ Company Name: ______________________

Address: ______________________________
____
____

Postcode: ______________ City/Town; ______________ Country ______________

Telephone No: ______________________ Fax No: ______________________

Email address: ______________________ Mobile phone: ______________________

Start date:____/____/____ End date:____/____/____ To date: ____/____/____

(B)

Name of Reference:____________________Company Name:____________________

Address: ____

____

____

Postcode:________________City/Town;____________Country____________

Telephone No:____________________Fax No:____________________

Email address:____________________Mobile phone:____________________

Start date:____/____/____ End date:____/____/____ To date: ____/____/____

BUILDING SOCIETY /BANK DETAILS

Bank Name: ____

Bank Address: ____

____

____

Building Society Bank Roll: ______________________________

Holders Account Name: ______________________________

Sort Code:____________________Account No:____________________

I authorise My Nursing Agency to pay my weekly wages into the above bank account and I will notify My Nursing Agency if changes occur to my details.

Signed______________________________Date____________________

NEXT OF KIN

Name of Emergency contact:____________________Relationship to you:____________________

Address:____

____

Post code: ____________________ Home Telephone: ____________________

Work No: ____________________Email Address: ____________________

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WORKING TIME REGULATIONS

I have read and understood the Working Time Regulations and I hereby consent that the working time limit shall not apply to my assignments

Print Name:______________________Signed:_________________________Date:_______________

FINAL STATEMENT

I declare that the information provided on this application is true to the best of my knowledge. I have read the terms and condition of engagement and agree to comply with the current Health and Safety at Work Act. I understand that my appointment is subject to the receipt of two satisfactory references and it subject to Enhanced CRB Disclosure. My Nursing Agency is free to make any other enquiries thy may find necessary relating to my application. I agree to respect the confidentiality of patients and clients and any other information I may have access to.

Signed:____Date:__ ....__________________

AGENCY INFORMATION. OFFICE USE

CHECKLIST		NOTES
Application		
Proof of Address	Utility bills, bank statements, others.	
Proof of identity	Passport, driving license others	
Eligibility to work	Visa, Work Permit, passport, birth cert	
CRB Application		
PAYE Form		
2 passport photograph		
Immunisation		
Signed contract		

AGENCY SIGN OFF

I Certify that I interviewed the above applicant in Accordance with **RELY CARE LIMITED** requirements and I am satisfied that this applicant is cleared for work

NAME OF CONSULTANT: ____

SIGNATURE OF CONSULTANT: ____

DATE: ____