**CANDIDATE APPLICATION FORM**

| Full Name: |
| --- |
| Position applied for: |
| Date Completed: |

Caring Health Services LLC requests you fill out this form honestly and accurately, as it is then used in the recruitment process to assess your suitability for temporary assignments.

Along with the completed Application Pack, we will need to sight the originals of the following documents:

* Passport and Visa (if app)
* Drivers Licence (if app)
* Proof of Address x2
* Proof of National Insurance
* CRB/DBS Disclosure Certificate
* Mandatory Training Certificates (Skills for Health Aligned)
* Qualification Certificates (NVQ in Health & Social care/ NMC Statement of Entry/ HCPC Certificate and Card/ GMC Certificate)
* Immunisations – (Hep B, Rubella, Measles, Varicella, BCG Scar and TB (HIV, HEP B Antigen and HEP C if EPP)

| **SOURCE** | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| How did you hear about Caring Health Services LLC? | | | | | | |
| If you were referred by a friend or colleague, please provide us with their name: | | | | | | |
| Availability: Full time |  | Part Time |  | Weekends |  |  |

**Please complete all sections using BLACK INK**

|  | **PERSONAL DETAILS** | | | | |
| --- | --- | --- | --- | --- | --- |
|  | Title: | Surname: | | | Forename: |
|  | Have you ever been known by any other name?  If yes, please specify the full name and dates used: | | | | |
|  | Date of Birth: | | | | |
|  | Current Address: | | | | |
|  | Home Phone: | | Mobile Phone: | | |
|  | Work Phone: | | Email Address: | | |
|  | National Insurance Number: | | Do you hold a valid U.S. Driver's Licence? Yes/No | | |
| **NEXT OF KIN DETAILS (Primary)** | | | | | |
| Full Name: | | | | Contact Number: | |
| Relationship to you: | | | | | |
| **NEXT OF KIN DETAILS (Secondary)** | | | | | |
| Full Name: | | | | Contact Number: | |
| Relationship to you: | | | | | |

| **RIGHT TO WORK** |
| --- |

| Are there any restrictions to your residence in the USA that might affect your right to take up employment in the USA? |  |
| --- | --- |
| If you are successful in your application would you require permission to work in the USA? |  |

| **TRAINING AND QUALIFICATIONS** | | | |
| --- | --- | --- | --- |
| HCPC/NMC/GMC Registration Number: | | | Date of Expiry: |
| Next Revalidation Date: | | |  |
| **Medical Indemnity Insurance – Nurse/Midwife Only**  Name of Insurer:  Policy Number:  Expiry Date (If Applicable): | | |  |
|  | |
| Where did you study and qualify? |  | | |
| What year did you qualify? |  | | |

**Previous employment** A full work history is required explaining any gaps in employment.

(Please continue on a separate sheet if necessary)

| Present/last employer |  | | | | |
| --- | --- | --- | --- | --- | --- |
| Address |  | | | | |
| Job Title |  | | | | |
| Duties/ Responsibilities |  | | | | |
| Reason for leaving |  | | | | |
| Previous Employers name & address | Job title | From | To | Reason for leaving |
|  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  | | | | | |
| R**EFERENCES** |

Please provide us with your referee details. Your referees must be either a Manager or Supervisor and be of a clinical state.

| CompanyName: | ContactNameandPositionofReferee: |
| --- | --- |
| Address: | |
| Phone: | Email: |
| DatesofEmployment: | |
| CompanyName: | ContactNameandPositionofReferee: |
| Address: | |
| Phone: | Email: |
| DatesofEmployment: | |
| CompanyName: | ContactNameandPositionofReferee: |
| Address: | |
| Phone: | Email: |
| DatesofEmployment: | |

| **HEALTH AND DISABILITY** |
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The following questions on health and disability are asked in order to find out your needs in terms of reasonable adjustments to access our recruitment service and to find out your needs in order to perform the job/position sought.

* Do you have any health issues or a disability which may make it difficult for you to carry out functions which are essential for the role you seek? Yes/No

If yes, please provide us with details

………………………………………………………………………………………………………………………………………

* If you have a disability, what are your needs in terms of adjustments?

Please provide us with details

………………………………………………………………………………………………………………………………………

| **HEALTH ASSESSMENT QUESTIONNAIRE** | Yes | No |
| --- | --- | --- |
| Have you had any medical problem in the past that has prevented you from working at night? |  |  |
| Are you diabetic? |  |  |
| Do you have angina, or other heart problems that may affect your fitness? |  |  |
| Have you had duodenal or stomach ulcers in the past, or are you under treatment for those at present? |  |  |
| Have you had any continuing bowel problems, for instance following major surgery? |  |  |
| Do you have any chronic chest problems such as asthma, emphysema or bronchiectasis? |  |  |
| Do you have any disability affecting mobility that will cause difficulties in arranging night work? |  |  |
| Do you have any recurrent or continuing sleep disturbance requiring medical advice? |  |  |
| Are you having specialist care requiring your attendance at hospital clinics for treatment? |  |  |
| Do you have any other health problem that affects your fitness for night work? |  |  |
| Are you taking any medication to a strict timetable? |  |  |
| Please give the names of any prescribed medications that you take regularly: |  |  |
| Please give any further details that you would like to bring to our attention. |  |  |

|  |
| --- |
| The Data Protection Act requires that any staff handling personal data must follow certain principles in relation to the data that they hold. Individuals have rights of access to data that is held and rights to claim for damages if various offences occur. This covers manual as well as computerised records.  In implementing the legislation, at Caring Health Services LLC we adopt a simple and straightforward policy.  If you are unsuccessful in this application, we will keep this form on file for 6 months should you wish to be considered for other vacancies.  Please tick to show your agreement to this. |

| **CRIMINAL RECORD CHECK/ ISA DECLARATION** |
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I have completed an application for a criminal record check and can further state that to the best of my knowledge and belief, there will not be any positive disclosure made that will preclude me from working with vulnerable adults or children.

I also give permission for a copy of the disclosure to which I am subject, being made available to a named authorised person upon written request, who acts on behalf of a National Government or Local Government Department for auditing purposes.

Name…………………………………………………………………...

Signature………………………………………………Date……………………………

| **WORKING WITH US** |
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It is our policy to employ the best qualified personnel and provide equal opportunity for the advancement of employees including promotion and training and not to discriminate against any person because of race, colour, ethnic origin, national origin, sex, sexual orientation, religion or belief, pregnancy, trans-gender status, marital or civil partnership status, age or disability.

I authorise Caring Health Services LLC to obtain references to support this application once an offer has been made and accepted. I release Caring Health Services LLC and referees from any liability caused by giving and receiving information.

| **EMPLOYEES CONSENT FORM** Caring Health Services LLC |
| --- |
| I confirm that my information can be shared with clients of Caring Health Services LLC and can be used for the payment of duties I carried out.  I agree that I may work for more than an average of 48 hours a week. If I change my mind, I will give my employer up to 3 months’ notice in writing to end this agreement. **Yes☐ No☐** |

| **DECLARATION** |
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I confirm that the information given on this form is, to the best of my knowledge, true and complete. Any false statement will be sufficient cause for rejection or, if employed, dismissal.

Name…………………………………………………………………...

Signature…………………………………………………………………

Date………………………………………………………………………..

Other Details