

|  |                 |
|--|-----------------|
| <b>MR/MRS/ MISS/ MS (please delete as appropriate)</b> |                 |
|  |                 |
| <b>FIRST NAME:</b>                                     |                 |
|  |                 |
| <b>MIDDLE NAME:</b>                                    |                 |
|  |                 |
| <b>SURNAME:</b>  |                 |
|  |                 |
| <b>DATE OF BIRTH:</b>                                  |                 |
|  |                 |
| <b>NATIONAL INS. NO.</b>                               |                 |
|  |                 |
| <b>ADDRESS</b>   |                 |
|  |                 |
| <b>POSTCODE:</b>                                       |                 |
| <b>HOME TEL:</b>                                       |                 |
| <b>MOBILE:</b>   |                 |
| <b>E-MAIL:</b>   |                 |
| <b>MARITAL STATUS:</b>                                 |                 |
|  |                 |
| <b>NEXT OF KIN:</b>                                    |                 |
| <b>RELATIONSHIP:</b>                                   |                 |
| <b>ADDRESS:</b>  |                 |
|  |                 |
| <b>POSTCODE:</b>                                       |                 |
| <b>PHONE NUMBER:</b>                                   |                 |
| <b>DO YOU HAVE PERMISSION TO WORK IN THE UK?</b>       | <b>YES / NO</b> |
| <b>DO YOU HAVE A VALID PASSPORT?</b>                   | <b>YES / NO</b> |
| <b>YOU HAVE A VALID WORK PERMIT?</b>                   | <b>YES / NO</b> |
|  |                 |
| <b>MOBILITY:</b>                                       |                 |
| <b>DO YOU HAVE ACCESS TO A CAR</b>                     |                 |
| <b>WHICH CAN BE USED FOR WORK PURPOSES?</b>            | <b>YES / NO</b> |
|  |                 |
| <b>DO YOU HOLD A FULL UK DRIVING LICENCE?</b>          | <b>YES / NO</b> |

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 |                   |
| 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,<br>Address & Tel no. | From | To | Position held, Duties and<br>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.

| <b>Occupational Health Assessment</b>  | <b>Yes</b> | <b>No</b> | <b>Details</b> |
|--|------------|-----------|----------------|
| <i>Are you in good health?</i>   |            |           |                |
| <i>How much time have you lost from work due to illness in the last five years?<br/>Please provide details</i> |            |           |                |
| <i>Have you ever been treated in hospital for serious illness or surgery? Please give dates</i>                |            |           |                |
| <i>Have you been treated in hospital during the last 12 months?</i>  |            |           |                |
| <i>Do you have any physical disabilities that could affect your ability to carry out your assignment?</i>      |            |           |                |
| <i>Have you ever left, been retired or denied a job on health grounds?</i>                                     |            |           |                |
| <i>Have you ever been denied a driving licence on health grounds?</i>  |            |           |                |
| <i>Are you a registered disabled person?</i>   |            |           |                |
| <i>Have you any disability related to your physical or mental health?</i>                                      |            |           |                |
| <i>Have you ever suffered from any mental illness, psychological or psychiatric problems?</i>                  |            |           |                |
| <i>Do you get discomfort or pain in the chest or shortness of breath on exercise?</i>                          |            |           |                |
| <i>Have you ever had any problems with your joints, including pain, swelling or stiffness?</i>                 |            |           |                |
| <i>Do you have any difficulty in moving rapidly over short distances?</i>                                      |            |           |                |
| <i>Would you have difficulty looking over either shoulder?</i>   |            |           |                |
| <i>Do you need to wear glasses or contact lenses?</i>  |            |           |                |
| <i>Do you have any difficulty with your eyesight which is not corrected by glasses or contact lenses?</i>      |            |           |                |
| <i>Have you any problems working with Visual Display Units?</i>  |            |           |                |
| <i>Have you any problems working in confined spaces/using lifts?</i>   |            |           |                |
| <i>Do you have any difficulty hearing normal conversation?</i>   |            |           |                |
| <i>Are you taking any medication that makes you dizzy or drowsy?</i>   |            |           |                |
| <i>Do you have a medical condition affected by changing sleeping patterns or affecting day time sleep?</i>     |            |           |                |
| <i>Have you suffered from any alcohol or drug related illness or had an alcohol or drug problem?</i>           |            |           |                |
| <i>Are you having or awaiting any treatment at the moment?</i>   |            |           |                |
| <i>What is the date of your last chest x-ray?</i>  |            |           |                |
| <i>Are you receiving Medicines, Pills or Tablets from a doctor or on prescription?</i>                         |            |           |                |
| <i>Have you ever suffered from any of the following?</i>   |            |           |                |
| <i>Heart Problems/Circulatory Illness/Hypertension</i>   |            |           |                |
| <i>High or Low Blood Pressure</i>  |            |           |                |
| <i>Diabetes</i>  |            |           |                |
| <i>Asthma/Hay fever</i>  |            |           |                |
| <i>Bronchitis/Pneumonia/Pleurisy</i>   |            |           |                |
| <i>Tuberculosis</i>  |            |           |                |
| <i>Epilepsy/Fainting Attacks/Blackouts/Fits/Sudden Collapse</i>  |            |           |                |
| <i>Headaches/Migraine</i>  |            |           |                |
| <i>Psychiatric Illness/Anxiety/Depression</i>  |            |           |                |
| <i>Dermatitis/Skin Sensitivity/Psoriasis/Eczema/Allergies</i>  |            |           |                |
| <i>Back Injury/Back Problems/Back Pains</i>  |            |           |                |
| <i>Recurrent Infections e.g. Sore Throats/Ear Infections/Eye Infections</i>                                    |            |           |                |
| <i>Hepatitis/Jaundice</i>  |            |           |                |

| 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   |        |         |
| <b>GP Name:</b><br>Address:<br><br>Postcode:<br>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.

| <b>WORK PREFERENCE: (Please tick)</b>  |          |
|--|----------|
| <i>Full time / Part time</i><br><i>If part time, how many hours per week do you want to work...</i><br><i>Home care and pop-in visits</i><br><i>Hospitals</i><br><i>Nursing/Residential Homes</i><br><i>Morning / Day / Evening / Night Sleeper duty</i> |          |
| <b>Live-In Care</b>  |          |
| <i>Please state if you are able to work as a 24-hour Residential (live-in) Carer.</i>  | YES / NO |
| <i>If YES, would you like:</i><br><i>Long..... or short ..... assignments?</i><br><i>Would you accept a live-in assignment some distance from your home?</i>   | YES / NO |
| <i>If NO, please specify preferred areas:</i><br><br><br>  |          |

## Care/Support Assistant ability schedule

Please indicate yes / No in the areas you have had previous experience.

| <b>Personal hygiene</b>                |               | <b>Care duties</b>                                   |               |
|--|---------------|--|---------------|
| <i>bath/shower/strip wash</i>          | <b>Yes/No</b> | <i>Pressure area care</i>                            | <b>Yes/No</b> |
| <i>bed bath</i>                        | <b>Yes/No</b> | <i>Simple dressing procedure</i>                     | <b>Yes/No</b> |
| <i>Use of bath aids</i>                | <b>Yes/No</b> | <i>Assisting with medication</i>                     | <b>Yes/No</b> |
| <i>Shaving</i>                         | <b>Yes/No</b> | <i>Terminal care</i>                                 | <b>Yes/No</b> |
| <i>Mouth care(inc. dentures</i>        | <b>Yes/No</b> |  |               |
| <i>Care of hair</i>                    | <b>Yes/No</b> | <b>Practical tasks</b>                               |               |
| <i>Care of feet(exc.toe nails)</i>     | <b>Yes/No</b> | <i>Light house work</i>                              | <b>Yes/No</b> |
| <i>Care of finger nails</i>            | <b>Yes/No</b> | <i>Washing personal laundry</i>                      | <b>Yes/No</b> |
| <i>Dressing/undressing</i>             | <b>Yes/No</b> | <i>Shopping</i>                                      | <b>Yes/No</b> |
|  |               | <i>Bed making/changing bed linen</i>                 | <b>Yes/No</b> |
| <b>Toileting</b>                       |               | <i>Collecting benefits</i>                           | <b>Yes/No</b> |
| <i>Continence care</i>                 | <b>Yes/No</b> |  | <b>Yes/No</b> |
| <i>Bedpans/commodoes etc.</i>          | <b>Yes/No</b> | <b>Admin. Abilities</b>                              |               |
| <i>Changing a catheter bag</i>         | <b>Yes/No</b> | <i>Confidentiality</i>                               | <b>Yes/No</b> |
| <i>Emptying catheter bag</i>           | <b>Yes/No</b> | <i>Report writing</i>                                | <b>Yes/No</b> |
|  |               | <i>Recording instructions from GP/DISTRICT NURSE</i> | <b>Yes/No</b> |
| <b>Mobility</b>                        |               | <i>Observing/recording</i>                           | <b>Yes/No</b> |
| <i>Maneuvering and handling course</i> | <b>Yes/No</b> | <i>Changes in clients condition</i>                  | <b>Yes/No</b> |
| <i>Use of hoists(man./elec)</i>        | <b>Yes/No</b> | <b>Previous exp.</b>                                 |               |
| <i>Use of walking aids</i>             | <b>Yes/No</b> | <i>Private house</i>                                 | <b>Yes/No</b> |
|  |               | <i>Nursing/residential</i>                           | <b>Yes/No</b> |
|  |               | <i>Home</i>  |               |

**EQUAL OPPORTUNITIES MONITORING**

***AZ Caring Services aims to be an equal opportunities 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 <input type="radio"/> | 21 – 35 <input type="radio"/> | 36 – 50 <input type="radio"/> | 50+ <input type="radio"/> |

|                         |                       |
|-------------------------|-----------------------|
| Registered disability   | <input type="radio"/> |
| Unregistered disability | <input type="radio"/> |
| No disability           | <input type="radio"/> |

|  |                       |
|--|-----------------------|
| Please tick appropriately which best describes your Ethnic Origin. |                       |
| White European   | <input type="radio"/> |
| White Other  | <input type="radio"/> |
| Black African  | <input type="radio"/> |
| Black Caribbean  | <input type="radio"/> |
| Black Other  | <input type="radio"/> |
| Indian   | <input type="radio"/> |
| Pakistani  | <input type="radio"/> |
| Chinese  | <input type="radio"/> |
| Other  | <input type="radio"/> |

How did you hear about the post?

.....

Are you related or do you know any member of AZ Caring Services.

.....



REHABILITATION OF EX- 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 1974 (Exceptions) Order 1975.*

*You are therefore required to give details of all convictions and cautions including 'spent' convictions. Any information, 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 AZ Caring Services.*

Have you ever been convicted of a criminal offence? **YES** | **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 Disclosure and Barring Service 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 **AZ Caring Services**, I will need to be in possession of a DBS Enhanced Disclosure.

Signature ..... Date ..... / ..... / .....

# **DOCUMENTS NEEDED FOR REGISTRATION**

- **VALID WORK PERMIT**

(Or if Student, College ID and Student Visa,)

- **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 apply with us.

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

# **RIGHT TO WORK ENQUIRY AGREEMENT**

I agree and give permission for AZ Caring Services to take appropriate action and contact the appropriate authorities as a part of their effort to validate my right to work in the UK.

**Print Name:**

**Signature:**

**Date:**

## **CONFIDENTIALITY AGREEMENT**

I agree that during the time I am engaged AZ Caring Services to work in any capacity:  
1. I will not disclose to any person, any information obtained whilst attending an assignment.  
2. I will hold in trust and confidence for AZ Caring Services all such information, and never use it in other than for the benefit of AZ Caring Services.

**Print name:**

**Signature**

**Date**

## **AZ Caring Services DECLARATION**

If you provide false or misleading information to support your application it will disqualify you from being engaged as an employee of AZ Caring Services.  
If it is found that you provided false or misleading information to support your application after or during employment, AZ Caring Services has the right to terminate your contract on this basis.

I hereby declare that I understand and complied with the requirements laid down in the application and I agree that the information given on this form maybe used to obtain DBS checks on me from the policy authorities.

**Name print**

**Signature**

**Date:**

**BANK DETAILS**

**Name**.....

**Account Name**.....

**Bank Name**.....

**Bank Address**.....

**Account Number**.....

**Sort Code**.....

**Signature**..... **Date**.....