APPLICATION FORM

first class care
PUTTING YOU FIRST

FIRST CLASS CARE DOMICILIARY AND CARE HOME

You must present as many of the following documents as possible at the interview:
Original Birth Certificate, OR Duplicate Birth certificate, Medical Card, Passport, Driving Licence, National Insurance Card, P45, P60, Utility Bills, Work Permit, Visa, or a letter from the Home Office confirming that you are allowed to work (see www.ind.homeoffice.gov.uk).

POST APPLIED FOR_____

PERSONAL DETAILS *(Please make all entries in block capitals, in black ink in the spaces provided)*

Full Name _____

Maiden Name _____

Date of Birth _____ Male/Female_____

Permanent Address Home Telephone Number_____

_____ Mobile Telephone Number_____

_____ Email Address_____

Postcode_____

N.I. Number___/___/___/___/___/___/___/___/___/

Work Permit Expiry Date _____ *(if applicable)*

Next of Kin_____ Relationship_____

Home Telephone Number _____ Mobile Telephone Number_____

Address _____

_____

_____

Email Address_____

ETHNIC ORIGIN										
Black			Indian	White	Arab	Pakistani	Bangladeshi	Chinese	Asian (Other)	Other (Please specify)
African	Caribbean	Other								

Driving Licence YES /NO Car Owner YES/NO

Reason for application_____

How did you hear about First Class Services?

☐ Newspaper/Magazine_____

☐ Local Advertisement_____

☐ Through Another Employee *(name)*_____

☐ Website/Internet *(please specify)*_____

☐ Other *(please specify)*_____

SECONDARY & FURTHER EDUCATION *(starting with most recent)*

Full-Time School/ College Attended	From	To	Qualification & Grades Achieved

PROFESSIONAL TRAINING & QUALIFICATIONS *(starting with most recent)*

Name & Address of Training Body	From	To	Qualification Achieved

EMPLOYMENT HISTORY *(Please list all previous employment starting with the most recent. Continue on separate sheet if necessary)*

Dates		Employers Name & Address	Department/Position & Duties	Reason For Leaving
From	To			

What are your main interests and hobbies?_____

_____

_____

PLEASE INDICATE WHY YOU HAVE APPLIED FOR THIS POST. (What qualities, experience etc. Please continue on a separate sheet if necessary.)

REFERENCES

Please give the names and addresses of two professional referees who are from previous employers and have knowledge of your professional ability. One of these must be your current or most recent employer. References must be from a senior line manger who knows you. Please supply details for two other References. These are for character references. These may **not** be persons related to you.

Reference 1		**Reference 2**	
Name		Name	
Position		Position	
Address		Address	
Tel. No.		Tel. No.	

Reference 3		**Reference 4**	
Name		Name	
Position		Position	
Address		Address	
Tel. No.		Tel. No.	

REHABILITATION OF OFFENDER ACT 1974

By virtue of the Rehabilitation of Offenders Act 1974 (Exception Order 75) the provisions of Section 4.2 of the Rehabilitation of Offenders Act l974 do not apply to any employment which is concerned with the provision of health services and which is of such a kind as to enable the holder to have access to persons in receipt of such services in the course of his normal duties. Your answer to the following question should therefore include any "spent" convictions. Have you ever received a caution, been convicted of a criminal offence including any spent convictions or have any outstanding pending prosecutions?
(N.B. a criminal conviction may not necessarily prevent applications from being processed; however, we will require further details at interview).

It is the Company's policy to instigate a Criminal Records Bureau (CRB) Enhanced Disclosure on all our prospective employees. Please sign and print your name here if you agree to such checks being carried out.

Name: _____

Signature: _____

Have you been involved in any Disciplinary Proceedings? Yes / No

If Yes, please give details, plus outcomes as appropriate.

The applicant is responsible for the accuracy of the declaration. Any false statement may render the applicant liable to dismissal.

I declare the information given on this application form to be complete and correct to the best of my knowledge.

Signed:_____

Date:_____

When you have completed this application form, please forward it to:

FIRST CLASS CARE LTD
83 – 85 Derby Road
Nottingham
NG1 5BB

The Health and Safety at Work Act imposes a general duty on all employers to ensure, so far is as reasonably practicable, the health safety and welfare at work of all their employees. Although only a few of our posts involve exposure to hazardous situations (as covered by the Control of Substances Hazardous to Health (COSHH) Regulations 1988) the Home considers it is desirable to screen all employees by requiring them to complete the attached Pre-Employment Health Questionnaire prior to the commencement of employment. Should you have any work related health problems in the course of your employment; the availability of this information will facilitate treatment.

Please note that the Pre-Employment Health Questionnaire form is CONFIDENTIAL. Its contents are subject to the provisions of the Access to Medical Reports Act and will therefore not be released by the Home to any third party without your prior written consent. Please therefore ensure that once you have completed the attached questionnaire you return it direct with your application form to the Home Manager.

Please also note that failure to provide this information or the giving of false information could affect the offer and/or your employment.

In the event that the Manager requires additional information to determine whether or not you are free from any physical defect or disease which impairs your capacity to undertake duty as a member of staff at First Class Care, you will be contacted and your consent (in writing) will be sought before any doctor or medical specialist is approached. At this stage you will be reminded of your rights under the provisions of the **Access to Medical Reports Act 1988.**

PRE-EMPLOYMENT HEALTH QUESTIONNAIRE

For Completion By Candidate

Name:		
Post:	Ref No:	Start date:
Department:	Section	

For office use only

Date received by Manager:
Recommendation:

THIS HEALTH QUESTIONNAIRE WILL REMAIN CONFIDENTIAL TO THE MANAGER

For Completion By Candidate

PLEASE READ THIS STATEMENT CAREFULLY BEFORE SIGNING

1. I declare that all the following statements are true to the best of my knowledge. I accept that in the event of my being employed and it subsequently being shown that medical information has not been disclosed by me, or has been misleading or false, that Pendean Nursing Home may terminate my employment.
2. I understand that I may be required to attend for consultation and physical examination.
3. I understand that although this form will be treated in medical confidence, further medical information may be requested from my doctor if considered necessary.

Signature: ..... Date: .....

1. Personal Details:

Surname: Forenames: Country of Birth:	Dr/Mrs/Mr/Ms/Miss: Date of Birth:
Address: Telephone:	**GP/Dr** Address: Telephone:

2. Job Applied For:

Job Title:

I believe the job involves exposure to/working with the following *(please tick)*:

- ☐ Contact with Service Users
- ☐ Contact with Body Fluids
- ☐ Working with VDU's
- ☐ Driving
- ☐ Chemicals
- ☐ Maintenance Work

3. Previous Employment:

Have you ever worked for First Class Services in the past? **Yes/No**

If yes, give details:

4. Health Details:

Do you suffer from allergies or ever had a reaction to any substance: **Yes/No**

If yes, give details:

What is your height?

What is your weight?:

Are you suffering from, or have your ever suffered from, any of the following? (If YES is answered to any of the questions, please give details of treatment and/or medication in the space on page 6):-

	Yes/No	At What Age?	Did you see your GP?	Did you see a Consultant?	No of days off
Heart disease of any kind	Y ☐ N ☐				
High blood pressure	Y ☐ N ☐				
Asthma, (shortness of breath)	Y ☐ N ☐				
Chest diseases	Y ☐ N ☐				
Persistent Cough	Y ☐ N ☐				
Unexplained weight loss	Y ☐ N ☐				
Indigestion	Y ☐ N ☐				
Frequent diarrhoea or constipation	Y ☐ N ☐				
Any form of bowel disease	Y ☐ N ☐				
Jaundice, gall bladder or liver disease	Y ☐ N ☐				
Hernia	Y ☐ N ☐				
Kidney disease or stones	Y ☐ N ☐				
Tropical disease	Y ☐ N ☐				
Back pain or disorder	Y ☐ N ☐				
Neck pain or disorder	Y ☐ N ☐				
Rheumatism or arthritis	Y ☐ N ☐				
Epilepsy or flicker epilepsy	Y ☐ N ☐				
Mental health problems	Y ☐ N ☐				
Stress at home or work	Y ☐ N ☐				
Eye disease or eye infection	Y ☐ N ☐				
Deafness or ear disease	Y ☐ N ☐				
Skin disease, eczema, psoriasis	Y ☐ N ☐				
Allergic conditions	Y ☐ N ☐				
Diabetes	Y ☐ N ☐				
Blood disorder, anaemia, or haemophilia	Y ☐ N ☐				
Any form of cancer	Y ☐ N ☐				
Any condition requiring surgery	Y ☐ N ☐				

	Yes/No	At What Age?	Did you see your GP?	Did you see a Consultant?	No of days off
Any work related medical condition	Y ☐ N ☐				
Bladder, prostrate, Testicular problems (males)	Y ☐ N ☐				
Irregular/painful periods (females)	Y ☐ N ☐				
severe headaches/migraine	Y ☐ N ☐				

Are you currently in good health? YES / NO

If yes to any of the following questions, please give details on page 11.

Have you had any illness or accident requiring admission to a hospital or clinic within the last two years? YES / NO

Have you attended any accident or emergency departments within the last two years? YES / NO

Have you had any major operations? YES / NO

Are you at present receiving any treatment from your doctor? YES / NO

Do you have any dental problems? YES / NO

Have you had a chest X-Ray in the last three years? YES / NO

Have you ever left or been denied a job or place on a course on health grounds? YES / NO

Are you on a disablement register? YES / NO
If so, please give number:_____

Are you attending an outpatient clinic or on a hospital waiting list? YES / NO

Have you ever been treated for abuse of an addictive substance? YES / NO

Are there any medical conditions which seem to run in the family? YES / NO

Have you any disabilities affecting standing/walking/lifting/driving stair climbing or use of the hands? YES / NO

Have you experienced any problems with Visual Display Units (VDU's) including visual problems, shoulder pain or wrist pain? YES / NO

Have you experienced any problems in confined spaces/using lifts? YES / NO

How many days sickness did you take in the last 12 months? _____

Do you smoke? If so, how many per day? _____

Do you drink alcohol? If so, how many units per week? _____
(approximate values are 1 pint = 2 units, 1 short = 1 unit, 1 glass of wine = 1 unit)

5. Vaccination History:

		Dates
Triple vaccine *(in childhood)*	YES/NO	_____
Tetanus	YES/NO	_____
Skin test (heaf/tine/mantoux) *(for tuberculosis)*	YES/NO	_____
BCG *(for tuberculosis)*	YES/NO	_____
Polio	YES/NO	_____
Hepatitis B	YES/NO	_____
Hepatitis B post vaccination blood test *(provide report if possible)*	YES/NO	_____
Rubella	YES/NO	_____
Others *(give details)*	YES/NO	_____

6. Infectious Diseases History:

Have you ever had any of the following diseases?

		Dates
Chicken Pox	YES/NO	_____
Shingles	YES/NO	_____
Tuberculosis	YES/NO	_____
Hepatitis A/B/C	YES/NO	_____
Food Poisoning	YES/NO	_____

FURTHER INFORMATION.

Please use this sheet to provide any further information you may wish to add.

Thank you for completing this health questionnaire.