

Fosse Home Care Application Form

Surname:	Forenames:
Maiden Name: (if applicable)	Date of Birth:
Nationality:	Religion:
Home Address:	Next of Kin: Relationship: Address:
Postcode: Home Tel: Mobile: Email:	Postcode: Telephone Number:

National Insurance Number:		Please confirm your immunisation status against the following:			
Are you eligible to work in the UK:	Expiry Date: (If applicable)	Hepatitis B	Yes / No	Varicella	Yes / No
Yes / No		Tuberculosis	Yes / No	Rubella	Yes / No
Own Transport:		Measles	Yes / No	Mumps	Yes / No
Yes / No					

Preferred Shifts: (circle as appropriate)	Do you have an NVQ qualification in Health and Social Care: Yes / No
Earlies/ Lates/ Long Days/ Nights	If yes, at what level: 2 3 4
	If no, are you currently studying towards one: Yes / No

Moving & Handling Certificate: Yes / No	If Yes, Expiry Date:	Basic Life Support Certificate: Yes / No	If Yes, Expiry Date:
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Please indicate which Client Groups you have experience of working with: (circle as appropriate)

Learning Disabilities Autism Challenging Behaviour Dementia Mental Health Elderly

Do you have a minimum of 12 months work experience within the following:

Residential Homes	Yes / No	Nursing Homes	Yes / No
Home Care	Yes / No	Day Services	Yes / No

Qualifications (Relevant to Healthcare / Nursing)

Qualification	Place where Obtained	Dates From: MM/YY	To: MM/YY

Only include below additional training you have a **valid** certificate of attendance for:

Course	Where obtained	Date completed (MM/YY)
Drug Administration		
Health & Safety		
Challenging Behaviour		
Adult Abuse		
Infection Control		
Fire Procedures		
Food Hygiene		

Employment History

(10 years work history required starting with the most recent first)

Name & Address of Employer	Dates DD/MM/YY	Position/Job Title	Reason for Leaving	Pay
<u>Name:</u> <u>Address:</u>	From: __/__/__			
	To: __/__/__			
<u>Name:</u> <u>Address:</u>	From: __/__/__			
	To: __/__/__			
<u>Name:</u> <u>Address:</u>	From: __/__/__			
	To: __/__/__			
<u>Name:</u> <u>Address:</u>	From: __/__/__			
	To: __/__/__			
<u>Name:</u> <u>Address:</u>	From: __/__/__			
	To: __/__/__			

Do you have any health issues or disabilities that will be prevent you from carrying out your duties as a Healthcare Professional to a satisfactory standard?

Yes / No

If yes, what are your needs in terms of reasonable adjustments to enable you to carry out your duties to a satisfactory standard?

Please specify:

Have you have been dismissed or had disciplinary action taken against you in the last 10 years?

Yes / No

Details:

References

(We can **only** accept work references from your Direct Line Manager **not** work colleagues. Please use **work contact details only** ensuring one reference is your current or most recent employer. We do not accept personal references)

Name: Position: Company Name: Address: Telephone No:	Name: Position: Company Name: Address: Telephone No:
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Rehabilitation Of Offenders Act 1974

In view of the nature of the work for which you are applying, this post is exempt from the provision of 2.4(2) of the Rehabilitation of Offender Act 1974 by virtue of the Rehabilitation of Offenders Act (Exceptions) Order 1975. Applicant are, therefore, not entitled to withhold information about convictions, which for other purposes are "spent" under the provision of the Act and, in the event of employment, any failure to disclose such convictions would result in dismissal. Any information given will be completely confidential and will be considered only in relation to this application.

Have you ever been convicted of a criminal offence by a Court of Law? Yes / No

Equal Opportunities

Fosse Healthcare is fully committed to the principle of Equal Opportunities in recruitment irrespective of colour, race, sex, marital status, sexual orientation, ethnic origin, nationality, religion, disability or age.

Declaration

I confirm that I have received a copy of the following documents and will adhere to the conditions and guidance enclosed within as follows:

- Staff Handbook
- Moving & Handling Handout

By signing this application I declare that all information given by me is accurate and in no way misleading or false.

SIGNATURE_____ **DATE**_____