

|  |
| --- |
| **Application Form**  |

As part of our recruitment process, the company collects and processes personal data relating to job applicants. The Company is committed to being transparent about how it collects and uses that data and to comply with data protection obligations. When you register, you give us consent to contact you via email and/or text message about recruitment activities. Once completed, please return the forms to us.

|  |  |
| --- | --- |
| **How did you hear about us?** |  |
| **Availability to start:** | **DD/MM/YYYY** |
| **English Language Proficiency:** |  |
| **Nationality:** |  |
| **Passport Number:** |  |
| **Visa Status:** |  |

|  |
| --- |
| **Personal Details** |

|  |  |
| --- | --- |
| **Title: (*Please specify*) e.g., Miss/Ms/Mrs/Mr** |  |
| **First Name:** |  |
| **Middle Name:** |  |
| **Surname:** |  |
| **Application Date:** |  |

|  |
| --- |
| **Personal Details** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Title: (Please specify) e.g., Miss/Ms/Mrs/Mr** |  | **Current Country:** |  |
| **First name(s):** |  | **Current City:** |  |
| **Middle Name:** |  | **National Insurance Number:** |  |
| **Last Name:**  |  | **Date of Birth:** |  |
|  |  | **Home Telephone:** |  |
| **Do you require a work permit to enable you to work in the UK?**  | ☐Yes ☐No  | **Mobile Telephone:** |  |
| **Applicant Address:** |  |
| **Email Address:** |  |

|  |
| --- |
| **Additional Information** |

|  |  |  |  |
| --- | --- | --- | --- |
| Do you hold a current full driving license?  | Yes ☐ | No ☐ | Not applicable ☐ |
| If yes, is it a clean driving license? | Yes ☐ | No ☐ | Not applicable ☐ |
| Do you have a right to work in the UK? | Yes ☐ | No ☐ | Not applicable ☐ |
| Do you have a criminal conviction? | Yes ☐ | No ☐ | Not applicable ☐ |
| How much care experience have you got? | None ☐ | 1+ Years ☐ | Less-than-a-year ☐ |

|  |
| --- |
| **Next Of Kin Details** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Next Of Kin Names:** |  | **Relationship to the Applicant:** |  |
| **Home Telephone:** |  | **Mobile Telephone:** |  |
| **Address:** |  |

|  |
| --- |
| **Education and Training** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date: From (Month/ Year)** | **Date: To****(Month/ Year)** | **Secondary School /College/University/ Training Organisation** | **Qualifications** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **Employment Experience** |

Please give details of your present or most recent employment/voluntary work first and work backwards. Include all periods of unemployment; travel etc, in the space provided so there are no gaps in the record. (If you have additional previous employment, please give details on a separate sheet using the same format).

| **Date: From (month/year)** | **Date: To (month/year)** | **Employer’s name and address and nature of business** | **Job titles and brief description of duties** | **Reason for leaving** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| **Gaps in your Employment** |

Please provide information of any gaps in employment

(Verification of employment gaps will be required if an offer of employment is made)

|  |  |  |
| --- | --- | --- |
| **From (month/year)** | **To (month/year)** | **Reason/s for the gap** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **References** |

Please ensure that you give a minimum of two references, which cover **at least the last five years of your employment.** The **first** of your references must be your **present employer and your relevant line manager.** If you are unemployed, this should be your last employer, or if this is your first job, your head-teacher or college tutor. Please note that we reserve the right to take up references in respect of **any** previous employment paid or unpaid, without further notification to you.

|  |  |
| --- | --- |
| **Current Employer / Organisation:** |  |
| **Name of Employer:** |  |
| **Job Title:** |  |
| **Organisation Address (in full):** |  |
| **Postcode:** |  |
| **Tel No.:** |  |
| **Email:** |  |
| **In what capacity do you know them? e.g., Manager, Deputy Manager, Senior worker, GP?** |  |

|  |  |
| --- | --- |
| **Character Reference** |  |
| **First Name / Surname:** |  |
| **Job title: (if Applicable)** |  |
| **Organisation address (in full):** |  |
| **Postcode** |  |
| **Tel No.:** |  |
| **Email:** |  |
| **In what capacity do you know them?** |  |

|  |
| --- |
| **Relevant Experience** |

Please tell us how your experience, skills and qualifications meet the requirements of the person and job profiles. Please focus your response on the abilities and/or competencies required for the role giving evidence of your experience to date (maximum of 2 A4 sheets). The information you provide will be the basis for shortlisting and you may find it useful to refer to the guidance notes attached before completing this section***.***

|  |
| --- |
| Write about your experience in health and social care.  |
|  |
| Write about your skills or transferable skills |
|  |
| Writer about your Qualifications.  |
|  |

|  |
| --- |
| **TO BE COMPLETED BY EMPLOYEE** |
| **I authorized** **to pay my weekly/ monthly earnings direct into the Bank/Building society Account whose details follow.****I will notify you** **in writing of any change to these details** |

|  |
| --- |
| **Declaration of Health** |

|  |
| --- |
| Please answer the following questions by ticking the appropriate **YES/NO** box. If the answer to any questions is **YES**, then give details in the space provided or on the back of this form. It is your responsibility to inform us immediately if any of the following information changes.Have you ever had in your life, including childhood, any of the following? |
|  | **Description of illness** | **Yes** | **No** | **Details / Dates** |
| **1** | COVID-19  | **☐** | **☐** |  |
| **2** | Cardiac/Vascular Illness | **☐** | **☐** |  |
| **3** | Visual defects/ Eye conditions (Including colour-blindness) other than those corrected by glasses? | **☐** | **☐** |  |
| **4** | Asthma, Bronchitis  | **☐** | **☐** |  |
| **5** | Tuberculosis | **☐** | **☐** |  |
| **6** | Diabetes | **☐** | **☐** |  |
| **7** | Epilepsy, Frequent Fainting Attacks  | **☐** | **☐** |  |
| **8** | Chicken Pox | **☐** | **☐** |  |
| **9** | Any Degree of hearing Loss | **☐** | **☐** |  |
| **10** | Hepatitis | **☐** | **☐** |  |
| **11** | Back pain, Sciatica | **☐** | **☐** |  |
| **12** | Do you have any deformities, which affect movement? | **☐** | **☐** |  |
| **13** | Are you receiving any medication from a doctor? | **☐** | **☐** |  |
| **14** | Have ever been treated for any other serious illness / operation | **☐** | **☐** |  |
| **15** | Are you a registered disabled person? | **☐** | **☐** |  |
| **16** | Mental Illness? | **☐** | **☐** |  |
| **17** | I believe that I am medically fit to carry out the duties of the position I have applied for | **☐** | **☐** |  |
| **18** | Are there any reasonable adjustments that an Employer should make to enable you to work? | **☐** | **☐** |  |
| **19** | Hearing defects / Ear conditions? | **☐** | **☐** |  |
| **20** | Speech or communication problems? | **☐** | **☐** |  |
| **21** | Severe anxiety, depression, other psychiatric disorders? | **☐** | **☐** |  |
| **22** | Paralysis or other psychiatric disorders? | **☐** | **☐** |  |
| **23** | Fainting attacks, blackouts, epilepsy, or fits? | **☐** | **☐** |  |
| **24** | Recurrent headaches, migraines? | **☐** | **☐** |  |
| **25** | Vertigo, giddiness, or tinnitus? | **☐** | **☐** |  |
| **26** | Heart disease, high blood pressure? | **☐** | **☐** |  |

|  |
| --- |
| **Please give details of last immunization or vaccination for** |

|  |
| --- |
| Tuberculosis:(We will require a statement of evidence regarding TB immunity i.e., Heaf / Mantoux status) |
| **Vaccination**  | **Yes** | **No** | **Date or Year of Vaccination** |
| COVID-19 Vaccination | **☐** | **☐** |  |
| Rubella (German Measles) | **☐** | **☐** |  |
| Poliomyelitis  | **☐** | **☐** |  |
| Varicella | **☐** | **☐** |  |
| Tetanus | **☐** | **☐** |  |
| Hepatitis B  | **☐** | **☐** |  |
| BCG | **☐** | **☐** |  |
| Influenza | **☐** | **☐** |  |
| Varicella (Chickenpox) | **☐** | **☐** |  |

|  |
| --- |
| **General Practitioner** |

|  |  |
| --- | --- |
| **General Practitioner’s Name:**  |  |
| **Address or Occupational Health Department:**  |  |
| I declare that all the foregoing statements are true and complete to the best of my knowledge and belief.I hereby given The Little Angels permission to contact my General Practitioner to obtain further information should it be required. |  |
| **Applicant Signature** |  |
| **Name (Please Print)** |  | **Date** |  |

|  |
| --- |
| **Availability Form** |

**Hours of Work**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full time** | **☐** | **Part time** | **☐** |

**Type of Work**

|  |  |  |  |
| --- | --- | --- | --- |
| **Domiciliary Care** | **☐** | **Live in Care** | **☐** |

|  |
| --- |
| **Hours Available** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Shift**  |  | **Time**  | **Other times (Please specify)** |
| Long day | **☐** | **07:00 to 07:00**  |  |
| Morning Shift | **☐** | **07:00 to 14:30** |  |
| Afternoon Shift | **☐** | **14:00 to 21:30** |  |
| Night Shift | **☐** | **20:00 to 08:00** |  |
| Other specify | **☐** | **09:00 to 23:00** |  |
| **Various shifts are available please enquire** | **☐** |  |  |

**Declaration - to be completed by all applicants.**

I confirm that the information I have given is correct and complete and that any false statements or omissions may render me liable to dismissal without notice or in some instances, referral to the police.

I understand and agree that data contained in the application form will be used and processed for recruitment purposes.

I also understand and agree that should I become an employee; the information will also be used for employment related purposes.

I agree to Three Little Angles holding and processing this information.

|  |  |
| --- | --- |
| **Signature** |  |
| **Name (Please print)** |  | **Date:** |  |