Application Form

PLEASE COMPLETE CAREFULLY IN BLACK INK

Title & Full Name:	Position applied for:
Address: Post Code:	Mobile Number:
Telephone Number:	Email Address:
Date of Birth:	National Insurance Number:
Nationality:	Professional Registration: (eg: NMC)
Proof of Employment: (Visa)	DBS disclosure number: 00
Passport Number:	DBS issue date:
Passport Nationality:	**Passport Issued:**

Next of Kin Details

Name:	Relationship:
Address: Post Code:	Email:
Telephone number:	Mobile number:

Payment Options - Bank Details

Bank Name:	*Your name as it appears on the card*
Bank Address: Post Code:	

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COMPANY REG: 10635906

Sort Code:	Account Number:

or **Limited Company**

Name of Company:	*Name of Company as it appears on Certificate of Incorporation*
Bank Address:	Post Code:
Business Account Details:	
Sort Code:	Account Number:

Qualifications and Training

Training	Date	Verified by *
Manual Handling Theory		
Manual Handling Practice		
Safeguarding of Vulnerable Adults		
Medication		
Risk Assessment *can be included in care certificate*		
Health and Safety		
COSHH *can be included in care certificate*		
CPR / Basic Life Support		
Fire Safety		
Infection Control		
Epilepsy Awareness *can be included in care certificate*		
Food Hygiene		

Any Other Training or Qualification

Training	Date	Verified by*

**Verification is done by VHM Care and copies of certificates taking for file*

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Employment History

*Please complete Employment History starting with current employer **

Name of Employer and Address	Job Role and Duties	Dates	Reason for leaving

* *Please continue on another page if needed*

Please explain any breaks in employment

Date of Gap	Reason

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References

Please list reference starting with most recent employer

Reference 1 - Current Employer

Name:	Role:
Address:	Post Code:
Telephone Number:	Email Address:
Can be contacted before interview	YES/NO

Reference 2

Name:	Role:
Address:	Post Code:
Telephone Number:	Email Address:
Can be contacted before interview	YES/NO

Reference 3 - Character Reference

Name:	Role:
Address:	Post Code:
Telephone Number:	Email Address:
Can be contacted before interview	YES/NO

Do you hold a valid driving licence: Yes / No

Licence Number………………………..………………………………

What transport do you have access to?

Private: ______________________ Public: __________________________

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Working Time Disclaimer:

You have the option to opt out of the 48-hour working week limitation, as laid down in the Working Time Regulation 1998.

Do you wish to opt out? YES / NO (delete as appropriate)

I understand that I may end this agreement by giving one week's notice in writing to VHM Care limited.

Signature: Date:

Rehabilitation of Offenders Act 1994:

Have you ever been convicted of a criminal offence and / or served a sentence or received preventative detention? YES / NO

At the time of signing this form is there any prosecution pending or has anything occurred which may result in a future prosecution against you?

YES / NO

I, the undersigned, undertake to inform you of anything which occurs in the future which may result in a prosecution

Signature: Date:

Declaration

I, to the best of my knowledge, have completed this application and believe that the information I have provided herein is accurate and true. By knowingly falsifying this document I understand that this could lead to dismissal.

I acknowledge that I have read the terms of engagement between myself and VHM Care limited and accept the conditions therein.

I confirm that I wish to have payments sent direct to the account detailed on page one of this application. I have checked these details and confirm that they are correct. During the course of my employment, should I be overpaid in error, I accept that any monies owed will be deducted out of my wages the following week.

Signature: Date:

Please return application form to: recruitment@vhmcare.com

Health Questionnaire

This questionnaire asks for information of a personal nature but it is necessary to establish your 'health status'. There are aspects of work which require us to make risk assessment in order to protect our employees and our clients. A result of the information given it may be necessary to request your permission to obtain further information from your General Practitioner. This would be done according to the guidelines of the Access to Medical Reports Act 1988, and therefore your cooperation and honesty in completing this questionnaire is appreciated.

Please tick the answer appropriate to you:

1. Have you had time off from work in the past two years due to sickness? YES / NO
2. If the answer to Q1 is Yes How many days?.......................................
3. Do you take regular medication? YES / NO
4. Have you ever had an operation? YES / NO
5. Have you ever been a patient in hospital? YES / NO
6. Are you awaiting a hospital admission or outpatient appointment? YES / NO
7. Do you smoke? YES / NO
8. Do you drink alcohol? YES / NO
9. Are you allergic to anything? YES / NO

if you've circled yes, then list here____

1. Have you ever or do you now suffer from : (please circle all that apply) Diabetes/ Epilepsy/ Asthma, bronchitis or TB/ Heart disease or high blood pressure/ Jaundice/ Blood borne virus (i.e. hepatitis/HIV) / Back problems/ Arthritis/ Any psychiatric problems/ Difficulty with vision or hearing/ Dysentery or typhoid/ Dermatitis, eczema or psoriasis
1. Please give last date of immunisation or vaccination of:
   Rubella (German measles)
   Tuberculosis
   Tetanus
   Hepatitis B
1. Last chest x-ray and date:
1. Have you ever been in contact with a person suffering from tuberculosis (TB)? YES / NO
1. When did you last consult your GP and why?

____

1. Name and address of your GP:

____

1. Your Height:
   Your Weight:
   Distinguishing marks:
1. Is there any additional information regarding your health not covered above?

____

____

____

I declare that the information I have given is correct and true to the best of my knowledge. Withholding information may lead to summary dismissal and may invalidate insurance.

Name ____________________________ Signature __________ ___________ Date _________________

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Equal Opportunity Monitoring

The information that you provide will be for the purpose of ensuring that the company properly monitors and confirm with its policies relating to quality and opportunity. All information will be held in the strictest confidence in accordance with the data protection legislation.

Please tick the following as appropriate:
I consider myself:

	Male
	Female
	Other

Ethnic Origin

African		Chinese		Mix ed	
Asian		European		Pakistani	
British White		European Other		Pilipino	
British Other		Hispanic		Other	
Caribbean		Indian			

If other please specify ……………………………………………

Please indicate your age in the ranges below

16-21		22-25		26-30	
31-35		36-40		41-50	
51-60		61-65			

Discrimination Act 1995

Do you consider that you have a disability: YES / NO
If Yes, please indicate the nature of the disability:………
Is this a registered disability: YES / NO
If YES, what is your registration number:………………………………..

Name ____

Signed ____

Date ____

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