APPLICATION DETAILS FOR EMPLOYMENT

POST APPLIED FOR:

PERSONAL DETAILS. Please complete in BLOCK LETTERS using black ink.

SURNAME:	TITLE: MR/MRS/MISS/MS/DR (DELETE AS APPLICABLE)
FORENAME(S) (IN FULL):	
MAIDEN NAME:	
ADDRESS: POST CODE:	
NATIONAL INSURANCE NUMBER:	
HOME TELEPHONE: WORK TELEPHONE: MOBILE PHONE:	E-MAIL ADDRESS:
DATE OF BIRTH:	NATIONALITY:
NEXT OF KIN'S NAME: RELATIONSHIP:	
NEXT OF KIN'S ADDRESS: TELEPHONE: POST CODE:	HOW DID YOU GET TO KNOW ABOUT US?

Driving license: Full UK Yes / No ..... Provisional Yes / No.....
International / Other .....

COMMUNICATION SKILLS:

	Language spoken	Level (Basic, Intermediate, Fluent)
1		
2		
3		
4		
Sign Language: Yes/No		Level: _____

EDUCATION & FORMAL TRAINING:
(Please complete in date order all educational institutions you attended **starting with the most recent**)

From – TO (MM.YYYY)	SCHOOL/ COLLEGE/ UNIVERSITY	QUALIFICATIONS	NVQ in Health and Social Care

EMPLOYMENT RECORD:
*(*Details of Full Employment History in chronological order Including **ALL GAPS** make sure you continue from education and **starting with the most recent**)

NAME AND ADDRESS OF EMPLOYER	DATE EMPLOYED FROM - TO (MM.YYYY)	POSITIONS HELD, DUTIES AND REASONS FOR LEAVING

Do you currently have any other Applications or interviews pending?
If so, please state details below:

REFERENCES:
Please provide the names and addresses of 2 Professional referees in the UK, 1 of who must be your most recent employer.

(Professional references will not be accepted from relatives or work colleagues in an official capacity on behalf of the organization or from people writing solely in the capacity of friends)

NAME: _____

ADDRESS: _____

_____

POST CODE: _____

TELEPHONE NO.: _____

Email: _____

OCCUPATION:_____

NAME: _____

ADDRESS: _____

_____

POST CODE: _____

TELEPHONE NO.: _____

Email: _____

OCCUPATION:_____

NAME: _____

ADDRESS: _____

_____

POST CODE: _____

TELEPHONE NO.: _____

Email: _____

OCCUPATION:_____

Do you have any family or close relation to any existing employee or employer: - Yes/No

(If Yes) Name and details: - _____

_____

I hereby authorize VITALCARE247 and present or past employers to give any information that may be requested concerning this application regarding my work, skills and character. I understand and agree to the passing on of references once I have accepted employment with a future employer. I agree to treat as confidential any information I receive concerning the business of VITALCARE247or its clients and not to disclose such information in any way other than as instructed by VITALCARE247 in connection with the business of VITALCARE247 in accordance with the company policy. I confirm that to the best of my knowledge the details I have provided on this application form is accurate and correct.

SIGNATURE _____

DATE _____

STANDARD PERSONAL STATEMENT FORM: EMPLOYEES STRICTLY CONFIDENTIAL

Candidate's Name:	Job Applied for:

Personal Statement

Please provide a statement as to why you would like to apply for the above role and why you also qualify for the role. Please fill in this information in the box below.

NAME : _____

SIGNATURE : _____

DATE : _____

HEALTH QUESTIONNAIRE – CONFIDENTIAL

Have you had any medical treatment in the last 1 year? Yes / No

If yes, please give details _____

Immunisations:

Have you been vaccinated, immunised or tested for/against any of the following?

	Yes	No	Details
Tuberculosis			
Rubella (German Measles)			
Poliomyelitis			
Hepatitis B vaccination (full course)			
Tetanus			
COVID Jabs			
Any Other? (Please include any medical condition other than specified here which may hinder efficiency of your work)			

Note

All Health Vaccinations certificate and hepatitis B status must be provided as part of the requirements by health authorities.

Only people who can demonstrate a satisfactory Hepatitis B status will be appointed to carry out high risk or invasive procedures.
Applicants are reminded that if they are HIV positive or suspect, they will be prohibited from invasive or high-risk work.
High risk group includes all Surgeons and Dentists, Midwives, all Scrub Nurses, staff in intensive care unit, Cardiologists undertaking catheterization, Renal Dialysis and Anesthetists.

NAME : _____

SIGNATURE : _____

DATE : _____

HAVE YOU HAD ANY OF THE FOLLOWING?

	Yes	No	Details & Dates
Migraine, Fits, Black outs or Epilepsy			
Asthma, Bronchitis, Pleurisy, Allergies			
Heart/Circulatory illness, High blood pressure			
Diabetes, Eye injuries or defective vision			
Nervous/ Mental disorder, Depression			
Have you had a recent chest x-ray?			
Prolonged back ache, hernia or arthritis			
Are you a registered disabled person?			(Cert. no)
Are you taking any medication at present?			
Any major operation or serious illness?			
Any Drug or Alcohol related illness?			
Do you smoke?			

Name & Address of GP: _____

_____

Post Code _____ Tel: _____

Note: Your General Practitioner may be contacted regarding your health and suitability to work.
DECLARATION

I declare that the information given above is true, to the best of my knowledge. I am permitted to work in the United Kingdom and I have read, understood and agree to the terms and conditions of work for temporary healthcare personnel, of which I have been given a copy with the introduction pack. I understand that my registration is subject to the receipt of **2 professional satisfactory references**.

I undertake to inform VITALCARE247 should I be convicted of an offence or any health issue in the future.

I undertake to inform VITALCARE247 immediately if I am engaged through VITALCARE247 introduction, including the offer of permanent employment following a temporary assignment.

I also acknowledge that this information may form the basis of a computerised personnel system to which I will have access as determined by the Data Protection Act 1984.

I agree to respect the confidentiality of clients, VITALCARE247 and any other information I may have access to at all times.

NAME : _____

SIGNATURE : _____

DATE : _____

THE WORKING TIME REGULATIONS 1998

Have been designed to implement the provision of the 1993 EC working time Directive and set down regulations which allow restrictions on the number of average weekly hours worked by employees

EMPLOYEE RIGHTS	FLEXIBILITY
• A limit of 49 hours on the average weekly working time. • A minimum of three weeks paid annual leave, rising to four weeks in November 2013. • Entitlements to daily and weekly rest periods. • Provision to limit the working hours for night workers. • The right for health assessment for workers involved in night working. • Where the employee agrees to work more than 48 hours per week, the Employer is required to provide compensatory rest period.	• To allow employers and employees to enter into agreement to allow for average working time in excess of 48 hours per week. • Workers engaged in security surveillance work. (Security Guards / Caretakers), in providing services relating to reception, treatment, or care, provided by hospitals, similar establishments, residential institutions, are exempt from the regulations governing rest periods and night work. • Employees who agree to work over 48 hours per week are entitled to compensatory rest periods.

DECLARATION AND AGREEMENT

I ¬¬¬¬¬¬¬¬¬¬¬¬¬¬_____ have been made aware of my rights as an employee under the provisions of the Working Time Regulations 1998, I hereby voluntarily agree to waive my rights under the regulations to restrict my average working weekly hours to 48. I accept that my employer may therefore require me to work more than an average 48 hours per week, and I understand that this Agreement should be read in conjunction with my terms and conditions of service.

Furthermore, I agree to be bound by this Agreement unless I give my employer three months notice in writing of my intentions to revoke this Agreement.

NAME : _____

SIGNATURE : _____

DATE : _____

STATEMENT OF CRIMINAL CONVICTIONS

Rehabilitation of offenders Act 1974 (Exceptions Order 75)

As the post for which you are applying is exempt from section 4.2 of the above Act, you are required to disclose information concerning convictions including those which for other purposes are regarded as "spent" under the Act. Any information given in this respect will be completely confidential and will be considered only in relation to this application. Failure to disclose any such convictions could result in dismissal or disciplinary action by the health authority.

Do you have any previous convictions? Yes No
If yes, please give details:

NATURE OF OFFENCE	DATE OF CONVICTIONS	DATE SPENT

I declare that the details given are correct.

Signature _____ Date _____

Applicants are required to have an enhanced DBS check carried out. Please note that a DBS is not portable and you will therefore be expected to have a DBS check done With VITALCARE247 (unless your DBS is registered with the update service) as part of your registration vetting process and you will be required to co-operate fully.

SURNAME _____ _____FORENAME(S) _____

_____I, the above named give permission for an enhanced DBS check to be carried out.

SIGNATURE _____ DATE: _____

Available Start Date :_____

Bank Details

BANK DETAILS

BANK OR BUILDING SOCIETY CURRENT ACCOUNT

BANK OR BUILDING SOCIETY NAME _____

BRANCH _____

SORT CODE _____

ACCOUNT NUMBER _____

ROLL NUMBER (IF BUILDING SOCIETY SAVING ACCOUNT)

_____

SIGNATURE _____

DATE: _____