



JOB APPLICATION FORM (CONFIDENTIAL)

Position applied for:

Job Reference:

Please complete this Application Form in block capitals in black or blue ink.

Should you require more space please continue on a separate sheet clearly marking the section to which it relates.

A: PERSONAL DETAILS

Title (Mr/Mrs/Miss/Ms/other): _____ Surname: _____

Forename(s): _____

Address: _____

Postcode: _____

Telephone: Home: _____ Mobile: _____ Mobile: _____

E-mail address: _____ This address is:

Personal ____ Work ____

Date of Birth: _____ Sex: Male ____ Female ____ Do you have permission to work in the UK? YES: ____ NO: ____

NATIONAL INS. NO. _____

NEXT OF KIN:

Name: _____

Tel: mobile/Landline _____ Relationship: _____

B: RIGHT TO WORK

DO YOU HAVE PERMISSION TO WORK IN THE UK? YES / NO

IF YES, (Please circle where appropriate) *You will need to submit proof of this.

• YOU ARE A MEMBER OF THE EEA _____ • YOU HAVE A VALID WORK PERMIT _____

• OTHER (PLEASE STATE) _____

Do you have regular use of a car? YES: ____ NO: ____

C: EDUCATION & PROFESSIONAL TRAINING (from year 11)

Education (school, college etc)	DATES		Qualifications gained
	from	to	
1. Secondary Education (secondary school)			
2. Higher Education (university / college / polytechnic)			
3. Further Education (Professional Training)			
4. Membership of Professional Organisation / Trade Union			
Relevant training/qualifications in healthcare		Certificates	
Examples:			
• Manual handling.....yes/ no		
• Health and safety.....yes/no		
• Basic food hygiene.....yes/no		
• First aid.....yes/no		
• NVQ Level.....yes/no		
• Others (please list).....		

D: EMPLOYMENT HISTORY (Please, also attach FULL CV)					
<i>Please provide details of all employment, beginning with your present or most recent job first</i>					
DATES		Employer	Salary	Position(s) held	Reason for leaving
from	to				
VOLUNTARY & COMMUNITY WORK EXPERIENCE					
DATES		Organisation	Position(s) held	Duties	
from	to				

E: REFERENCES	
<p>Please provide details of 2 referees who we may approach with regards to this Job Application. These referees must not be members of your family, and one must be your present or most recent employer:</p>	
<p>1. Name: _____</p>	
<p>Address: _____</p> <p>_____</p>	
<p>Telephone Number: _____ Email: _____</p>	
<p>Occupation: _____</p>	
<p>2. Name: _____</p>	
<p>Address: _____</p> <p>_____</p>	
<p>Telephone Number: _____ Email: _____</p>	
<p>Occupation _____</p>	
<p>May we contact your referees prior to making a job offer? YES: ___ NO: ___</p>	

F: JOB FLEXIBILITY

Prepared to work: FULL-TIME: _____ PART-TIME: _____ SHIFTS: _____

If PART-TIME please indicate preferred hours: _____

Please provide details of any outstanding holidays to be taken: _____

AVAILABLE TO TAKE UP EMPLOYMENT FROM: _____

G: MEDICAL HISTORY

Please answer all of the following questions.

Have you ever had or do you have now any of the following?

1. An impairment, which may affect your ability to work safely or perform your duties?

2. Eyesight problems not corrected with glasses or contact lenses?

3. Hearing problem not corrected with a hearing aid?

4. Difficulty in standing, bending lifting or other movements?

5. Any kind of skin problem

6. Are you aware of MRSA guidelines and the need of screening?

7. Any muscular, skeletal problems, including arthritis? Any kind of back problem?

8. Any psychiatric or psychological conditions, including stress at work?

9. Suffered significant discomfort when using key board?

10. Fits, blackout or epilepsy?

11. Any allergies?

12. Any accidents, which have significantly affected you physically or mentally?

13. Asthma, Bronchitis, or chest problems?

14. Treatment for Tuberculosis (TB)?

15. In the last 12 months, have you had a cough for more than 3 weeks, ever coughed up blood, had any unexplained loss of weight or fever?

16. Any gastrointestinal problem including Hepatitis?

Yes No

	Yes	No
1. An impairment, which may affect your ability to work safely or perform your duties?		
2. Eyesight problems not corrected with glasses or contact lenses?		
3. Hearing problem not corrected with a hearing aid?		
4. Difficulty in standing, bending lifting or other movements?		
5. Any kind of skin problem		
6. Are you aware of MRSA guidelines and the need of screening?		
7. Any muscular, skeletal problems, including arthritis? Any kind of back problem?		
8. Any psychiatric or psychological conditions, including stress at work?		
9. Suffered significant discomfort when using key board?		
10. Fits, blackout or epilepsy?		
11. Any allergies?		
12. Any accidents, which have significantly affected you physically or mentally?		
13. Asthma, Bronchitis, or chest problems?		
14. Treatment for Tuberculosis (TB)?		
15. In the last 12 months, have you had a cough for more than 3 weeks, ever coughed up blood, had any unexplained loss of weight or fever?		
16. Any gastrointestinal problem including Hepatitis?		

17. Diabetes, thyroid or Endocrine problems?		
18. Any cardio – vascular problems including hypertension? Any blood disorder?		
19. Dysentery, Typhoid, paratyphoid, food poisoning, Salmonella, Severe Gastroenteritis or diarrhoea?		
20. Seen the doctor in the last one year for any kind of health problem?		
21. Any operations in the past 2 years?		
22. Are you at present receiving or taking any form of medication?		
23. Frequent headaches or episodes of Migraine?		
24. A drug or alcohol problem?		
25. Would you regard yourself as having a disability		
26. Is there any additional relevant medical information not covered in the above questions?		

If you have answered yes to any of the questions above, please give details below. (Continue on a separate sheet if required)

Question no.	

H: MONITORING

Please tick all the relevant boxes.

This information is used for monitoring purposes only. It will be treated as confidential.

Ethnic group

African _____ Afro- Caribbean _____ Asian _____ UK/European _____
Other European _____ Other (please specify) _____

Disability

Do you consider yourself as having a disability? Please state _____

I: CRIMINAL RECORD CERTIFICATES

If the position you are applying for (whether paid or voluntary) is listed in Schedule 1, Part II of the *Rehabilitation of Offenders Act (Exceptions) Order 1975*, we are entitled to ask Exempted Questions as defined by Section 113(5) of the *Police Act 1997* about you. We are required to acquire a DBS Certificate in relation to any person who is a Care Manager or Care/Support Worker. This means that if your application is successful we will obtain from the Criminal Records Bureau a DBS Certificate relating to you before your appointment is confirmed.

Having a criminal record will not necessarily bar you from working with us. This will depend upon the nature of the position and the circumstances and background of your offences. We observe the "Code of Practice for Registered Persons and Other Recipients of Disclosure Information" published by the Criminal Records Bureau on behalf of the Home Office and we will provide you with a copy of it upon request.

Signature: _____ Date: _____

J: DECLARATION BY JOB APPLICANT

ANY PERSON, UPON SUBSEQUENT EMPLOYMENT, THAT IS FOUND TO HAVE KNOWINGLY SUPPLIED FALSE OR MISLEADING INFORMATION, OR HAS DELIBERATELY WITHHELD RELEVANT INFORMATION, MAY BE SUBJECT TO DISCIPLINARY PROCEEDINGS WHICH MAY RESULT IN DISMISSAL

I have read and understood the information supplied to me in relation to this Job Position, and the information requested in this Job Application Form. I confirm that all information supplied by me is true and correct to the best of my beliefs.

I give the prospective employer the right to follow up all references and to make any other job-related enquiries as may be deemed necessary.

Signature: _____ Date _____

EVERGREEN HEALTH CARE SERVICES LTD IS AN EQUAL OPPORTUNITY EMPLOYER

The sole criterion for selection of applicants will be suitability for the Job Position, regardless of gender, background, culture, ethnic denomination, religious affiliation, marital status or disability. *Data Protection Act, 1998*: Your signature on this document gives us the right, under the *Data Protection Act, 1998* to process the information you have given, including data of a sensitive nature, relating to your application for employment. Any processing of the data by us will be in accordance with our Policy and the processing principles set out in the Act. Application forms of unsuccessful candidates will be destroyed after 6 months in accordance with our Record-keeping Policy.

Please, send completed application form to our office or email: info@evergreenhcs.co.uk

Evergreen Healthcare Services

6 Bevan Court, Unit 5, Wellingborough, Northamptonshire, NN8 4BL

DOCUMENTS NEEDED FOR REGISTRATION

To support the application, please attach the documents below if available:

(Birth Certificate, Training Certificates, Driving License, Visa/ Work permit, NI Card and Proof of address.)

- **N&MC Pin Card**
(For nurses)
- **VALID WORK PERMIT**
(Or if Student, College ID and Student Visa,)
- **BRITISH PASSPORT**
(Or other current Home Office Document authorising you to work in UK)
- **NATIONAL INSURANCE (NI) CARD**
(Or P45 or P60 or letter confirming you have applied for NI)
- **HEALTHCARE WORKER MANDATORY TRAINING CERTIFICATES**
- **CRIMINAL RECORDS BUREAU CERTIFICATE (CRB) - DBS** or you can apply with us.
- **PROOF OF ADDRESS**
E.g. Driving Licence, Utility Bill, or any formal letter with your name and address
- **2 CURRENT PASSPORT SIZE PHOTOGRAPH**
- **Full CV**