

APPLICATION FORM

3 County Care is an equal opportunities employer

POSITION APPLIED FOR _____

PERSONAL DETAILS

Full Name: Mr/Mrs/MS _____

Address: _____

Postcode: _____

Home Telephone No: _____ Work Telephone No: _____

Mobile Telephone: _____ Email Address: _____

Nationality: _____ Religion: _____

Type of Transport: _____ Do you hold a UK Driving Licence: _____

National Insurance Number:

Pin: (Qualified Nurse Applicants only) Pin expiry Date: _____

Name of Emergency Contact: _____ Relationship to you: _____

EMPLOYMENT DETAILS - Currently employed? YES NO

Company: _____

Position: _____ Period Employed From/To: _____

Reason for leaving: _____

Company: _____

Position: _____ Period Employed From/To: _____

Reason for leaving: _____

Company: _____

Position: _____ Period Employed From/To: _____

Reason for leaving: _____

EDUCATION AND TRAINING

Name and address of School/College/Nurse Training School/Other	Course or subjects taken and (any) qualifications gained	From: Mth/Yr	To: Mth/Yr

LANGUAGES

Please list the languages in which you are fluent (including your Mother tongue) _____

WHICH OF THE FOLLOWING HAVE YOU WORKED IN BEFORE

- Learning Disabilities Mental Health Prisons Day Centres
 Physical Disabilities Nursing Home General Hospitals Nurseries
 Challenging Behaviour Home Care Psychiatric Services Children

SHIFTS PREFERRED

Part Time Full Time AM PM Nights

Areas that can be covered: _____

Date available to start: _____

REHABILITATION OF OFFENDERS ACT 1974

By virtue of the Rehabilitation Act 1974 (Exemptions) (Amendments) Order 1986, the provisions of sections 4.2 of the Rehabilitation of Offenders Act 1974 do not apply to any employment which is concerned with the provision of health services and which is of such a kind as to enable the holder to have access to persons in receipt of such services in the course of his/her normal duties.

Your answer to the following question should include any 'spent' convictions.

Have you ever been convicted of a criminal offence:

If 'yes' please give details on a separate sheet.

YES

NO

DOH circular (88/9) Protection of Children requires us to carry out checks on police records for members whose assignments will give them substantial access to children.

Do you agree that such checks may be made concerning you, if required?

YES

NO

Do you have a current CRB?

REFERENCES

Please provide details of 2 referees who can provide information relating to your competence in a caring role (one of whom should be your present or most recent employer). Relatives and friends are not acceptable.

1. Name _____	Position _____
Address _____	Organisation _____
_____	Telephone No. _____
_____ Postcode _____	<u>YES</u> <u>NO</u>
May we approach the above prior to interview?	<input type="checkbox"/> <input type="checkbox"/>
2. Name _____	Position _____
Address _____	Organisation _____
_____	Telephone No. _____
_____ Postcode _____	<u>YES</u> <u>NO</u>
May we approach the above prior to interview?	<input type="checkbox"/> <input type="checkbox"/>

HEALTH QUESTIONNAIRE

All information is held in confidence

1. Have you ever suffered from or are suffering from:

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Back related problems	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Nervous Breakdown/mental disorder	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart or Circulatory Illness	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders or anaemia	<input type="checkbox"/>	<input type="checkbox"/>
Dysmenorrhoea	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent attacks of diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered yes to any of the above please give details

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
2. Have you ever had any major accidents or head injuries?	<input type="checkbox"/>	<input type="checkbox"/>	5. Have you been immunised against:		
If yes please give details _____			Rubella (German Measles)	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had any major operations or illnesses?			Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
If yes please give details _____			Tetanus	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have or are you a carrier of any communicable disease?			Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
If yes please give details _____			Polio	<input type="checkbox"/>	<input type="checkbox"/>
			6. Do you have any allergies (eg. penicillin)	<input type="checkbox"/>	<input type="checkbox"/>
			If yes please give details _____		

7. Please give details of your height _____ Weight _____ Blood Group _____

8. Are you currently receiving any medication or treatment if yes please give details

	<u>YES</u>	<u>NO</u>	
9. Are you a smoker?	<input type="checkbox"/>	<input type="checkbox"/>	12. How many days off sick have you had in the last 12 months?
10. Are you at this time pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Have you ever been refused employment on health grounds?	<input type="checkbox"/>	<input type="checkbox"/>	13. Name, address and telephone number of next of kin

PERSONAL SKILLS

Please answer as honestly as possible as this will help in choosing your work

BANK DETAILS

Wages are paid direct into account. Please give below details of the account you would like your wages paid into:

Name and Address of Bank or Building Society: _____

Name of Account Holder: _____

Type of Account (current, deposit etc) _____

Account Number _____ Sort Code _____

Reference Number (if Building Society) _____

I hereby request and authorise your to remit all amounts due to me for credit of the account detailed above.

Signed: _____ Date: _____

DECLARATION

I confirm that I am 18 years if age, or over.

I fully accept that I am applying for membership of 3 County Care, in the full comprehensive and understanding that should I accept an introduction from 3 County Care the services that I provide are on a self employed basis. As a self employed person, I accept that 3 County Care duty is that of an agent, not employer and in signing this disclaimer I acknowledge that neither 3 County Care, nor its employees, hold any responsibility or liability whatsoever for the services that I provide, nor for the consequence of the provision of such services, including personal accident, damage to client's property etc.

I declare that all the information given is true and I understand that any false or misleading information may result in my removal from the 3 County Care Register of Members.

I have read and agreed to abide by the conditions of membership.

I accept my duty to inform 3 County Care of any change in circumstances that may affect my employment status.

I can confirm that I am eligible to work in the UK.

Signed: _____ Date: _____