

2nd Floor, 53b East Street, Barking, Essex IG11 8EN
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EMPLOYMENT APPLICATION

Weston Care is an equal opportunity employer, which means employment decisions regarding prospective qualified employees are dealt without regard to race, colour, sex, religion, national origin, age, disability, marital status or sex change status or any other factor protected by law.

Please complete all sections using CAPITAL LETTERS and return with required documents:

Position applied for: _____ DATE: _____

Where did you hear about this vacancy? _____

Personal Details

Surname: _____ Forename: _____ Title: _____

Address: _____

Postcode: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

May we contact you at work? [] YES [] NO

Please note that all applicants are required to provide evidence of permission to work in the United Kingdom.

Nationality: _____ Immigration Status: _____

NI number: _____ NMC Pin Number: _____ NMC Expiry Date: _____

NMC Part(s) of register: _____

Are you a member of any union? [] YES [] NO

If yes please give details: _____

Do you hold a current driving licence? [] YES [] NO Do you have your own transport? [] YES [] NO

NEXT OF KIN DETAILS

Name: _____ Relationship: _____

Address: _____

Postcode: _____

Telephone Day: _____ Evening: _____

EMPLOYMENT HISTORY: Please supply details of your employment history for a period of at least 5 years duration starting with your most recent/present position first. Please explain any gaps in employment.

Employer's Name & Address	Principal duties	Grade	Date: From	Date: To	Reasons for leaving

Education Details
School Name and Address: _____

Postcode: _____

Dates of attendance. From: _____ To: _____

Subjects and Grades: _____

Further Education and training details (including details of nurse training: _____

Please list any other professional qualifications: _____

Mandatory Training Requirements
It is a mandatory requirement that the following training is updated annually. Please supply details as requested and original certificates as evidence.

Subject	Training provider	Date certificate expires
Moving and Handling		
Fire Safety		
Health and Safety (including Acts of 1974 & 199; and COSHH and RIDDOR)		
Infection Control		
Cardio-pulmonary resuscitation		
CPR for newborns and cardiocograph traces (for midwives_		

Work Preferences: Please tick as appropriate (Section For Nurses only)

A& E	<input type="checkbox"/>	Clinics	<input type="checkbox"/>	Community	<input type="checkbox"/>	Elderly Care	<input type="checkbox"/>
EMI	<input type="checkbox"/>	General	<input type="checkbox"/>	Gynaecology	<input type="checkbox"/>	Health Visitor	<input type="checkbox"/>
Home Care	<input type="checkbox"/>	ITU (psychiatric)	<input type="checkbox"/>	ITU	<input type="checkbox"/>	Learning Disabilities	<input type="checkbox"/>
Medical	<input type="checkbox"/>	Mental Health	<input type="checkbox"/>	Midwifery	<input type="checkbox"/>	Neonatal	<input type="checkbox"/>
Nursing Homes	<input type="checkbox"/>	Occupational Health	<input type="checkbox"/>	OPD	<input type="checkbox"/>	Orthopaedics	<input type="checkbox"/>
Paediatrics	<input type="checkbox"/>	Practice Nurse	<input type="checkbox"/>	Recovery	<input type="checkbox"/>	Renal	<input type="checkbox"/>
SCBU	<input type="checkbox"/>	Surgical	<input type="checkbox"/>	Theatres	<input type="checkbox"/>	Urology	<input type="checkbox"/>

Midwives
Date of last refresher course: _____ Establishment attended: _____

Practising [☐] YES [☐] NO

Staff Task Ability Schedule: Please tick as appropriate (Section for Carers and support workers only)

Bath/shower/strip wash	<input type="checkbox"/>	Bed making	<input type="checkbox"/>
Catheter	<input type="checkbox"/>	Pressure area care	<input type="checkbox"/>
Patient moving and handling	<input type="checkbox"/>	Dressing and undressing	<input type="checkbox"/>
Mouth care	<input type="checkbox"/>	Changing urine bag	<input type="checkbox"/>
Feeding and toilet care	<input type="checkbox"/>	Reporting and recording	<input type="checkbox"/>
Simple dressing procedures	<input type="checkbox"/>	Terminal care	<input type="checkbox"/>
Assisting with medications	<input type="checkbox"/>	Bedpans/commodes	<input type="checkbox"/>
Report writing	<input type="checkbox"/>	Continence Care	<input type="checkbox"/>
Moving and handling/Use of hoists/walking aids/	<input type="checkbox"/>	Observation of clients conditions	<input type="checkbox"/>

AWARENESS

Infection control	<input type="checkbox"/>	MRSA	<input type="checkbox"/>
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Work preference

Please state the areas in which you would prefer to work: _____

What type of work you are looking for:

☐ Full time ☐ Part Time ☐ Permanent ☐ Occasional Work

☐ Weekdays ☐ Nights ☐ Weekends

Do you have any specific availability (e.g. set days per week): _____

In which geographical area do you wish to work: _____

Do you speak any languages in addition to English?

Written: _____ Spoken: _____

Language	Fluent	Good	Fair	Fluent	Good	Fair

Professional References: Please supply the names and work addresses of two professional referees. One must be from your present or most recent employer and must be a senior grade to yourself and you must have worked for that person for a period of not less than three months duration.

Referee 1

Name: _____ Position: _____

Work Address: _____

_____ Postcode _____

Telephone: _____ Fax: _____

In what capacity and how long has this person known you: _____

Referee 2

Name: _____ Position: _____

Work Address: _____

_____ Postcode _____

Telephone: _____ Fax: _____

In what capacity and how long has this person known you: _____

May we contact your referees prior to your interview?

Referee 1 ☐ YES ☐ NO

Referee 2 ☐ YES ☐ NO

Declaration of Health

Please state whether you have or have not suffered from any of the following. Where the question has prompted a "yes" response from you please enter details in the comments box and state the dates.

Description of illness	YES	NO	Comments
Cardio/Vascular illness including chest pain, high blood pressure, low blood pressure			
Eye disease/injury or defect of vision not corrected by glasses			
Asthma, Bronchitis, Pleurisy, Pneumonia or other chest illnesses			
Tuberculosis			
Diabetes, thyroid or other glandular problems			
Epilepsy, frequent fainting attacks, giddiness or migraine			
Chicken pox, German measles, poliomyelitis, dysentery, rheumatic fever, jaundice			
Any degree of hearing loss			
Hepatitis A, B or C			
Prolonged or sever back ache, back injury, neck injury?			
Do you have any illness that affects your movement?			
Are you currently taking any prescribed medication?			
Have you ever been treated for any other serious illness or operations?			
Do you have any allergies?			
Do you suffer from dermatitis, psoriasis, melanoma or other skin complaints?			
Are you registered disabled?			
Are there any reasonable adjustments that an employer should make to enable you to work?			
Have you ever suffered with depression, mental illness or a nervous breakdown?			
Have you any reason to believe you may be infected by any communicable diseases?			
Have you knowingly been in contact with MRSA or worked within a MRSA environment?			

Immunisation Details

Evidence of immunisation status for Hepatitis B, Rubella, Tuberculosis and Varicella is required in the form of a lab report from an occupational Health Department or a letter from your GP.

Tuberculosis: _____ Rubella: _____

Varicella: _____ Hepatitis B: _____

Tetanus: _____ Date of last chest X-Ray: _____

Additional information: _____

General Practitioner Name and Address: _____

Post code: _____

I hereby give Weston Care permission to contact my GP to obtain further information should it be necessary.

I declare that the answers given within this declaration of Health are true and complete to the best of my knowledge and belief. I understand that making false statements or failure to declare health problems could lead to my removal from the Weston Care register.

Signature: _____ Date: _____

Rehabilitation of Offenders Act

Because of the nature of the work for which you are applying, the provision of Section 4 (2) of the Rehabilitation of Offenders Act (1974) (exceptions) Order 1975. Applicants are therefore required to give information about convictions which for other purposes are "spent" under the provisions of the Act. Any information given will be completely confidential and will be considered only in relation for positions to which the order applies.

Have you at any time been convicted of any offence? [] YES [] NO

If yes please give details? _____

It is a condition of proceeding with your application that you apply for an "enhanced" CRB disclosure or produce a disclosure which you have already obtained. Convictions and any other criminal record information obtained through the Criminal Record Bureau's Disclosure service will not necessarily be a bar to employment. All circumstances will be taken into account. However, any inconsistencies compared with the information given above may invalidate your application.

Inspection and Data Protection Act

Part of the inspection process under the Care Standards Act 2000 involves the local registration and inspection units having access to your personnel file held at Weston Care Offices to ensure that Weston Care are maintaining the correct information required under the Care Standards Act. Your permission is required for inspectors to view your file.

Please record your consent below.

I **do/do not** give consent for my file to be inspected by the Care Quality Commission.

Signature: _____ Date: _____

Declaration

I confirm that the information given in this application is, to the best of my knowledge, true. I am permitted to work in the UK. I have read, understood and agree to the conditions of work for temporary nurses, carers and domestic staff, of which I have been given a copy. I understand that my registration is subject to the receipt of at least two satisfactory references and enhanced disclosure from the criminal Records Bureau.

I undertake to inform Weston Care should I be convicted of an offence in the future. I undertake to inform Weston Care immediately if a ma engaged through Weston Care's introduction, including the offer of permanent employment following a temporary assignment. I agree to respect the confidentiality of patients and any other information I may have access to at all times.

For the purposes of the Working Time Regulations 1998 (as amended), I consent to work in excess of an average of 48 hours per week. I understand that I may withdraw this consent by giving Weston Care not less than three months' written notice.

Your registration with Weston Care can be terminated at any time following unsatisfactory work reports.

Signed: _____ Date: _____