

LEVENTIS CARE SERVICES Ltd

Telephone: 02081096718
Email: info@leventiscare.co.uk

Healthcare Assistant/Support Worker Application Form

Title of Post Date

Area

PERSONAL DETAILS

Name in Full Title (Dr/Mr/Ms etc)

Address Marital Status

..... Maiden Name

..... D.O.B.....

(Post Code) Religion

Telephone No (Home) Mobile

Email: N.I. No.

Place of Birth Nationality

How did you hear of the vacancy?

Do you hold a current driving Licence?

Type of driving licence Full ☐ Provisional ☐

Do you own a car?

Do you require a work permit? Yes / No Expiry Date

NEXT OF KIN

Name

Address

.....

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.....
.....
Telephone Number

Right to work in the UK

The Asylum and Immigration Act 1996 makes it a criminal offence for Leventis Care to employ any persons who do not have the right to live and work in the United Kingdom.

All British citizens must complete their national insurance details. If you are a non British citizen but have the right to live and work in the United Kingdom please ensure you complete the sections on work permits and/or visas and national insurance number (if applicable).

You will be required to provide documentary evidence of your right to Leventis Care.

I certify that the information provided on the application is correct and that I have a right to work in the UK.

Declaration:
Please sign

Date:

To be completed by Non British Citizens

Visa reference:

Visa issued date:

Visa expiry date:

Work permit number:

Work permit expiry date:

Residency permit number:

Residency permit expiry date:

National Insurance number:

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EMPLOYMENT HISTORY AND REFERENCES

Please give full details of employment history and referees during the past 10 years, starting with the most recent first. (All gaps must be accounted for in the spaces provided, please use a continuation sheet if necessary)

1. CURRENT EMPLOYER

Title of post Name of Employer

From (Month/Year) To (Month/Year)

Full or Part-Time Salary

Main responsibilities

.....

.....

.....

.....

Reason for Leaving:

Address:

.....

.....

Post Code:

Tel. No:

Contact:

Contact Email:

(Please explain any gaps in employment:)

2. PREVIOUS EMPLOYER

Title of post Name of Employer

From (Month/Year) To (Month/Year)

Full or Part-Time Salary

Main responsibilities

.....

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.....
Reason for Leaving:

Address:
.....
.....

Post Code:

Tel. No:

Contact:

Contact Email:

(Please explain any gaps in employment:)

3. PREVIOUS EMPLOYER

Title of post Name of Employer

From (Month/Year) To (Month/Year)

Full or Part-Time Salary

Main responsibilities
.....
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.....
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Reason for Leaving:

Address:
.....
.....

Post Code:

Tel. No:

Contact Email:

4. PREVIOUS EMPLOYER

From (Month/Year) To (Month/Year)

Full or Part-Time Salary

Main responsibilities

Reason for Leaving:

Address:

Post Code:

Tel. No:

Contact:

Contact Email:

(Please explain any gaps in employment:)

Have you ever been dismissed from any employment? Yes ☐ No ☐

Please note: We retain the right to seek references from all previous employers

Date:

Signed: Signed:
Applicant Leventis Care Staff

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HEALTH QUESTIONNAIRE

All members are required to complete this Health Declaration (any positive answers will not necessarily affect your application)

	Yes	No	Details
Have you ever been treated at a hospital for serious illness or surgery (please give details)			
How much time have you lost from work due to illness in the last five years? (please provide details)			
Are you a registered disabled person?			
What is the date of your last chest x-ray?			

Have you ever suffered from any of the following:	Yes	No	Details
Heart/Circulatory Illness/Hypertension			
Diabetes			
Asthmas/Hayfever			
Bronchitis/Pneumonia/Pleurisy			
Tuberculosis			
Epilepsy/frequent Fainting Attacks			
Headaches/Migraine			
Psychiatric Illness/Anxiety Depression			
Dermatitis, Skin Sensitivity (Allergies) Psoriasis/Eczema			
Back Injury/Back Problems or Back Pains			
Recurrent Infections e.g. Sore Throats/Ear Infections			
Hepatitis/Jaundice			

	Yes	No	Details
Are you receiving medicines, pills or tablets from a Doctor or on prescription			

	Yes	No	Details
Do you have any physical disabilities other than those listed above that could affect your ability to carry out your assignment?			

Have you even been Vaccinated, Immunized or Tests for/against any of the following?

	Yes	No	Details
Tuberculosis including BCG			
Heaf, Mantoux or Tine			
Rubella (German Measles)			
Poliomyelitis			
Hepatitis B			
Hepatitis B Antibodies (Date and Result)			
Tetanus			
Typhoid			

Any Other (**Provide Details**)

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Please enter your height and weight Height (cm) Weight (kg)

Do you smoke? Yes No

I declare that the statements are true and complete to the best of my knowledge and belief, I understand that my General Practitioner may be consulted with my prior consent

Signed Date

General Practitioners Name

Address and Telephone of GP.....

REHABILITATION OF OFFENDERS ACT

Because of the nature of the work for which you are applying, this post is exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974 by virtue of the Rehabilitation of Offenders Act 1975 (Exception) Order 1975. Applicants are therefore, not entitled to withhold information about convictions which for other purposes are “spent” under the provisions of the Act and in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action. Any information given will be completely confidential and will be considered only in relation to an application for positions to which the Order applies, and should be entered at the end of any particular you give in support of your application.

Criminal Conviction Yes ☐ No ☐

If yes, please provide details below

PLEASE GIVE ANY ADDITIONAL INFORMATION WHICH YOU THINK MAY BE RELEVANT IN SUPPORT OF YOUR APPLICATION (Continue on a separate sheet if necessary)

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DECLARATION

I declare that the particular in this form are to the best of my knowledge complete and true

Signed Date

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FOR OFFICIAL USE ONLY

Outcome of Interview

PIN CHECKED

REFS APPLIED 1) REC

..... 2) REC

POLICE CHECK APPLIED

VERBALLY REF'D

ALL DOCUMENTATION REMAINS THE PROPERTY OF THE COMPANY

PROFESSIONAL CARE QUALIFICATIONS (To be completed by Interviewer)

Date **Qualification** Evidence Yes / No

Date **Qualification** Evidence Yes / No

Date **Qualification** Evidence Yes / No

WHICH COURSES HAVE YOU COMPLETED?

Care of Elderly	<input type="checkbox"/>	Administering Medication	<input type="checkbox"/>
Lifting and Manual Handling	<input type="checkbox"/>	Learning Difficulties	<input type="checkbox"/>
NVQ	<input type="checkbox"/>	Health & Safety	<input type="checkbox"/>
Behavioural	<input type="checkbox"/>	Mental Health	<input type="checkbox"/>
First Aid	<input type="checkbox"/>	Auxiliary Nursing	<input type="checkbox"/>

IN WHAT AREAS DO YOU HAVE EXPERIENCE?

Learning Disabilities	<input type="checkbox"/>	Hospitals	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	Community	<input type="checkbox"/>
Challenging Behaviour	<input type="checkbox"/>	Nursing Homes	<input type="checkbox"/>
Physical Disabilities	<input type="checkbox"/>	Social Worker	<input type="checkbox"/>
Day Centres	<input type="checkbox"/>	Support Worker	<input type="checkbox"/>
Residential Homes	<input type="checkbox"/>	EMI	<input type="checkbox"/>
Geriatric	<input type="checkbox"/>	Terminal Care	<input type="checkbox"/>
Elderly Dementia	<input type="checkbox"/>	Hospice	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	Home Care	<input type="checkbox"/>
Frail	<input type="checkbox"/>	Acute	<input type="checkbox"/>

EVIDENCE OF TRAINING (To be completed by Interviewer)

Qualification: **Certificate Verified:** Yes / No

Qualification: **Certificate Verified:** Yes / No

Qualification: **Certificate Verified:** Yes / No

LEVENTIS CARE

General Questions for Healthcare Assistant/ Support Worker

(Hospitals, Care Homes, Home Care, Mental Health and Learning Disability Homes)

What excites you about working in adult social care?

Why does this appeal to you?

What parts do you think you would most enjoy?

What interests you about our organisation in particular?

How did you become aware of us?

What excites you about working as a (HCA/Support Worker) and what sorts of things have you been doing that you think could help you become a good (HCA/Support Worker)

Can you give an example where someone in your organisation came to you with a concern?

How did it feel to you?

How did you respond?

In this role you will need to work with the minimum of supervision. Describe a recent example which proves your ability to work independently in a proactive way.

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What were the main challenges and obstacles you faced?

How did you motivate yourself?

What did you find most challenging & how did you overcome it?

What mistakes did you make & what have you learnt from them?

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