# **HEALTHCARE ASSISTANT APPLICATION FORM**

# **Personal Information**

|  |  |
| --- | --- |
| Surname: | Forenames: |
| Maiden Name (if applicable): | Date of Birth: |
| Nationality: | NI Number: |
| Passport Number :  | Passport Expiry Date:  |
| Mobile Number: | Email: |
| Marital Status: | Driver’s License: Yes [ ]  No [ ]   |
| Home Address:Postcode: Home Tel:Mobile:Email: | Gender: MALE [ ]  FEMALE [ ]  OTHER [ ]  |
| Next of Kin Name:Relationship: Address:Postcode:Telephone Number: |
| Enhanced DBS Disclosure Number (if applicable): |
| Are you eligible to work in the UK? YES [ ]  NO [ ]  Expiry Date (If applicable): |
| Do you have your own transport? YES [ ]  NO [ ]  |
| Please confirm your immunisation status against the following:Hepatitis B: YES [ ]  NO [ ]  Tuberculosis/ BCG: YES [ ]  NO Measles: YES [ ]  NO [ ] Varicella: YES [ ]  NO [ ]  Rubella: YES [ ]  NO [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Preferred shifts (circle as appropriate): EARLIES [ ]  LATES [ ]  LONG DAYS [ ]  NIGHTS [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have an NVQ qualification in Health and Social Care? YES [ ]  NO [ ] If yes, at what level? 2 [ ]  3 [ ]  4 [ ]  If no, are you currently studying towards one? YES [ ]  NO [ ]  |
| Do you have a Moving & Handling certificate? YES [ ]  NO [ ]  If Yes, Expiry Date:  |
| Do you have a Basic Life Support certificate? YES [ ]  NO [ ]  If Yes, Expiry Date: |
| Please indicate which client groups you have experience of working with (mark as appropriate):ELDERLY [ ]  YOUNG ADULTS [ ]  ACUTE MENTAL ILLNESS [ ]  DEMENTIA [ ]  LEARNING DISABILITIES [ ]  |
| Do you have a minimum of 6 months work experience within the following?Residential Homes: YES [ ]  NO [ ]  Nursing Homes: YES [ ]  NO [ ]  |

**Qualifications** (Relevant to Healthcare / Nursing only)

|  |  |  |  |
| --- | --- | --- | --- |
| Qualification | Where Completed | Date From (MM/YY) | Date To (MM/YY) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Only include below additional training you have a valid certificate of attendance for:

|  |  |  |  |
| --- | --- | --- | --- |
| **Course** | **Where Completed** | **Date Completed (DD/MM/YY)** | **Date Expires****(DD/MM/YY)** |
| Drug Administration |  |  |  |
| Safeguarding Adults |  |  |  |
| Equality & Diversity |  |  |  |
| Food Hygiene |  |  |  |

# **Current and Previous Employment History**

(Work history required starting with the most recent first)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name & Address of Employer | Dates (DD/MM/YY) | Position/ Job Title | Reason for Leaving | Salary  |
| Name:Address: | From: / / |  |  |  |
| To: / / |
| Name:Address: | From: / / |  |  |  |
| To: / / |
| Name:Address: | From: / / |  |  |  |
| To: / / |
| NOTES (eg. gaps in work history): |

**MEDICAL HISTORY**

Have you ever suffered from any of the following?

|  |  |  |
| --- | --- | --- |
| Heart/Circulatory Illness/Hypertension | YES [ ]  | NO [ ]  |
| Diabetes | YES [ ]  | NO [ ]  |
| Asthma/Hay fever | YES [ ]  | NO [ ]  |
| Bronchitis/Pneumonia/Pleurisy | YES [ ]  | NO [ ]  |
| Epilepsy | YES [ ]  | NO [ ]  |
| Headaches/Migraine | YES [ ]  | NO [ ]  |
| Tuberculosis | YES [ ]  | NO [ ]  |
| Psychiatric Illness/Anxiety/Depression | YES [ ]  | NO [ ]  |
| Dermatitis/Psoriasis/Eczema | YES [ ]  | NO [ ]  |
| Back problems | YES [ ]  | NO [ ]  |
| Recurrent infections | YES [ ]  | NO [ ]  |
| Hepatitis/Jaundice | YES [ ]  | NO [ ]  |
| Are you taking any prescription drugs? | YES [ ]  | NO [ ]  |

If you have answered yes to any of the above questions, please give details below:

Do you have any health issues or disabilities that will prevent you from carrying out your duties as a Healthcare Professional to a satisfactory standard? YES [ ]  NO [ ]

If yes, what are your needs in terms of reasonable adjustments to enable you to carry out your duties to a satisfactory standard? Please specify:

Have you been dismissed or had disciplinary action taken against you in the last 3 years?

YES [ ]  NO [ ]

Details:

# **References**

(We can only accept work references from Line Managers, not work colleagues. Please use work contact details only, ensuring one reference is from your current or most recent employer. We do not accept personal references. Please note; references must cover a 3-year period where applicable).

|  |  |
| --- | --- |
| Name:Position:Company Name:Address:Telephone No:Email: | Name:Position:Company Name:Address:Telephone No:Email: |
| Name:Position:Company Name:Address:Telephone No:Email: | Name:Position:Company Name:Address:Telephone No:Email: |

# **Rehabilitation Of Offenders Act 1974**

In view of the nature of the work for which you are applying, this post is exempt from the provision of 2.4(2) of the Rehabilitation of Offenders Act 1974 by virtue of the Rehabilitation of Offenders Act (Exceptions) Order 1975. Applicants are, therefore, not entitled to withhold information about convictions, which for other purposes are “spent” under the provision of the Act and, in the event of employment, any failure to disclose such convictions would result in dismissal. Any information given will be completely confidential and will be considered only in relation to this application.

Have you ever been convicted of a criminal offence by a Court of Law (please indicate)? YES [ ]  NO [ ]

**IF YOU HAVE A CONVICTION/CAUTION RELATING TO A VIOLENCE OR THEFT OFFENCE, WE WILL BE UNABLE TO PROGRESS WITH YOUR APPLICATION.**

# **Equal Opportunities**

Open Doors Healthcare is fully committed to the principle of Equal Opportunities in recruitment irrespective of colour, race, sex, marital status, sexual orientation, ethnic origin, nationality, religion, disability or age.

# **Declaration**

I confirm that I have received the Open Doors Healthcare Services Pvt Ltd conditions and terms and will adhere to the conditions and guidance enclosed.

By signing this application, I declare that all information given by me is accurate and in no way misleading or false.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to Open Doors Healthcare Services checking the details I have provided against the various data sources in order to verify my identity and process the application. These details may be recorded and used to assist other organisations for identity verification purposes such as the CRB/DBS, regulatory bodies such as NMC or GSCC

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Our agency retains the right to hold this application and any other data required to process this application (whether in the UK, or elsewhere) and keep for as long as necessary in line with the data protection act.