

**PART - A**

# Shifa Health & Social Care

**Application Form**

PLEASE ADD YOUR PICTURE IN THE BOX BELOW

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| POSITION APPLIED FOR |  | DEPARTMENT | Choose an item. | DATE |  |  |
| FULL NAME |  | | | | |
| DATE OF BIRTH |  | | | AGE |  |
| LANGUAGES YOU CAN SPEAK? |  | | | | |

**CONTACT DETAILS**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| HOME ADDRESS |  | | | | | | | | |
| CITY |  | | | | POST CODE |  | | | |
| DO YOU HAVE  UK/EEA DRIVING  LICENSE | YES |  | NO |  | DO YOU HAVE  A CAR? | YES |  | NO |  |
| MOBILE NO. |  | | | | HOME TELEPHONE |  | | | |
| EMAIL ADDRESS |  | | | | | | | | |

**EMERGENCY CONTACT DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| NEXT OF KIN NAME |  | RELATION TO YOU |  |
| NEXT OF KIN MOBILE NUMBER |  | NEXT OF KIN TELEPHONE NUMBER |  |

IF YOU ANSWER YES TO ANY QUESTION BELOW, PLEASE EXPLAIN ON THE LAST PAGE OF PART A IN EXTRA COMMENTS

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HAVE YOU BEEN DISMISSED FROM ANY EMPLOYMENT? | YES |  | NO |  |
| HAVE YOU EVER BEEN OR CURRENTLY SUBJECT TO ANY INVESTIGATION OR DISCIPLINARY ACTION? | YES |  | NO |  |
| HAVE YOU EVER BEEN CONVICTED, SANCTIONED, OR HAVE AN OUTSTANDING WARRANT OR CAUTION? | YES |  | NO |  |
| HAVE YOU EVER LEFT A JOB WITHOUT NOTIFIYING EMPLOYEER? | YES |  | NO |  |

COVID 19 VACINATION

HAVE YOU BEEN DISMISSED FROM ANY EMPLOYMENT?

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| HAVE YOU BEEN VACINATED FOR COVID 19? | | | | | | YES | |  | NO | |  |
| 1ST JAB |  | DATE TAKEN |  | 2ND JAB |  |  | DATE TAKEN | | |  | |

PLEASE PROVIDE EVIDANCE OF VACCINATION TAKEN

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HAVE YOU EVER WORKED IN THE UK BEFORE? | YES |  | NO |  |

**WORK EXPERIENCE**

IF NO PLEASE GO TO THE NEXT PAGE

WORK EXPERIENCE FOR LAST 5 YEARS

If you have worked before applying this job, you must write the employer’s details as referee on next page.

We will not accept any personal reference in case you have a work history.

If you never worked before please write what you have been doing last 5 years.

PLEASE NOTE THAT WHOME EVER DETAILS YOU PROVIDE BELOW WILL ALSO BE REQUIRED AS REFERENCES FOR YOUR APPLICATION AND WILL BE APPROCHED BY SHIFA HEALTH & SOCIAL CARE

IF THESE RECORDS DO NOT MATCH YOUR APPLICATION WILL NOT BE PROCESSED

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| (most recent) COMPANY NAME |  | YOUR JOB  TITLE |  | | |
| ADDRESS |  | START DATE |  | END DATE |  |
| MAIN DUTIES |  | | | | |
| REASON FOR LEAVING THIS JOB |  | | | | |
| REASON FOR GAP |  | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| (2nd recent) COMPANY NAME |  | YOUR JOB  TITLE |  | | |
| ADDRESS |  | START DATE |  | END DATE |  |
| MAIN DUTIES |  | | | | |
| REASON FOR LEAVING THIS JOB |  | | | | |
| REASON FOR GAP |  | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| (3rd most recent) COMPANY NAME |  | YOUR JOB  TITLE |  | | |
| ADDRESS |  | START DATE |  | END DATE |  |
| MAIN DUTIES |  | | | | |
| REASON FOR LEAVING THIS JOB |  | | | | |
| REASON FOR GAP |  | | | | |

**SUPPORTING STATEMENT**

|  |
| --- |
| Please tell us why you applied for this job and why you think you are the best person for the job.  NOTE: FOLLOW THE JOB DESCRIPTION AND PERSON SPECIFICATION |
|  |

IF RQUIRED PLEASE CONTINUE ON A SEPERATE PAGE

**REFERENCES**

**Professional Reference:** (if you have worked before, your reference should be from your most recent employer. Manager / HR

**Personal Reference:** Your reference should be from someone who knows you for 1 year or more, Referee should not be your relative or best friend, your referee should be a professional person

**Institutional Reference:** It could be from your Institution (college, University, Training Centre, supervision, assessor, trainer or a teacher).

**Years Known:** If the personal referee does not know you for more than 1 year, you may have to provide 4 references instead

Please Note we will be sending Reference Forms to all your below mentioned referees

**REFERENCES 1:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please tick what reference is this** | | **EMPLOYER** |  | **PERSONAL** | | |  | **INSTITUTIONAL** |  |
| REFEREE TITLE & FULL NAME |  | |  | | COMPANY  NAME |  | | | |
| REFEREE JOB  TITLE |  | |  | | REFEREE  CONTATACT NUMBER |  | | | |
| EMAIL ADDRESS |  | |  | | | | | | |
| FULL WORK ADDRESS |  | |  | | | | | | |
| IN WHAT CAPACITY / RELATIONSHIP HAVE YOU KNOWN THE  REFEREE | | |  | | | | | | |
| HOW LONG HAVE YOU KNOWN ABOVE MENTIONED PERSON? | | |  | | | | | | |

**REFERENCES 2:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please tick what reference is this** | | **EMPLOYER** |  | **PERSONAL** | | |  | **INSTITUTIONAL** |  |
| REFEREE TITLE & FULL NAME |  | |  | | COMPANY  NAME |  | | | |
| REFEREE JOB  TITLE |  | |  | | REFEREE  CONTATACT NUMBER |  | | | |
| EMAIL ADDRESS |  | |  | | | | | | |
| FULL WORK ADDRESS |  | |  | | | | | | |
| IN WHAT CAPACITY / RELATIONSHIP HAVE YOU KNOWN THE  REFEREE | | |  | | | | | | |
| HOW LONG HAVE YOU KNOWN ABOVE MENTIONED PERSON? | | |  | | | | | | |

PLEASE ASK FOR ADDITIONAL PAGES IF REQUIRED FOR MORE REFERENCES TO INPUT

|  |
| --- |
| QUALIFICATIONS, SKILLS, EXPEREINCE AND COMPETENCY CHECK  QUALIFICATION IN HEALTH AND SOCIAL CARE (QCF/ NVQ LEVEL 1, 2, 3,4 OR 5) |

|  |  |
| --- | --- |
| PLEASE WRITE ONLY THE HIGHEST QUALIFICATION OBTAINED | DATE OF COMPLETION |
|  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HAVE YOU COMPLETED SKILL FOR CARE “CARE CERTIFICATE” BEFORE?**  (If yes, please provide company name below also provide us the care certificate document.) | YES |  | NO |  |
|  | DATE OF COMPLETION | |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HAVE YOU OBTAINED ANY OTHER DAY TRAININGS IN HEALTH AND SOCIAL CARE?**  (If yes please provide the certificates.) | YES |  | NO |  |
|  | DATE OF COMPLETION | |  | |
|  | DATE OF COMPLETION | |  | |
|  | DATE OF COMPLETION | |  | |

**EDUCATION / QUALIFICATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **PLEASE WRITE THE DETAILS OF YOUR HIGHEST EDUCATION / QUALIFICATION**  PROVIDE QUALIFICATION / EDUCATION CERTIFICATE | | | |
| QUALIFICATION /EDUCATION |  |  |  |
| PLACE OF COMPLETION |  | DATE OF COMPLETION |  |

**EXTRA COMMENTS**

|  |
| --- |
| please tell us if you have any other comments you would like to share |
|  |

**PERSONAL DECLARATION**

|  |  |  |  |
| --- | --- | --- | --- |
| I hereby confirm that the information provided on my application is correct and true to the best of my knowledge and that I have not withheld any information that should be taken into account when offering me work. I understand that providing false/inaccurate information may result in the termination of employment.  If you are not selected, the application and documents will be destroyed safely. | | | |
| NAME |  | **SIGNATURE**  TYPE NAME IF SENDING  BY EMAIL |  |
| DATE |  | FOR OFFICE USE (RECEIVED BY) HR  SIGNATURE |  |

IF THE PERSON HAS BEEN SHORT LISTED, GIVE THE 2ND PART OF APPLICATION

**PART - B**

**EQUAL OPPORTUNITY FORM**

**APPLICATION PART 2**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ONLY SUCCESSFUL APPLICANTS WILL BE REQUIRED TO COMPLETE THE EQUAL OPPORTUNITY | | | | | | |
| APPLICANT NAME |  | | | | | |
| GENDER | MALE |  | FEMALE |  | PREFER NOT TO SAY |  |
| MARITIAL STATUS | MARRIED |  | SINGLE |  | PREFER NOT TO SAY |  |
| SEXUAL ORIENTATION | BISEXUAL |  | GAY |  | HETROSEXUAL |  |
| LESBIAN |  | OTHER |  | PREFER NOT TO SAY |  |
|  | IF “OTHER”, PLEASE SPECIFY |  | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **RELIGION** | BUDDHIST |  | CHRISTIAN |  | CHURCH OF SCOTLAND |  |
| HINDU |  | JEWISH |  | ROMAN CATHOLIC |  |
| MUSLIM |  | SIKH |  | NO RELIGION |  |
| PREFER NOT TO SAY |  | OTHER |  |  |  |
| IF “OTHER”, PLEASE SPECIFY |  | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **ETHINIC ORIGIN** | BANGLADESHI |  | CHINESE |  | INDIAN |  |
| PAKISTANI |  | AFRICAN |  | CARIBBEAN |  |
| WHITE |  | EUROPEAN |  | OTHER |  |
| IF “OTHER”, PLEASE SPECIFY |  | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **DISABILITY** | DO YOU CONSIDER YOURSELF OR HAVE ANY DISABILITY | | YES |  | NO |  |
|  | IF “YES”, PLEASE SPECIFY |  | | | | |

**HEALTH MONITORING**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **ONLY SUCCESSFUL APPLICANTS WILL BE REQUIRED TO COMPLETE A DETAILED MEDICAL QUESTIONAIRE** | | | | | | | |
| 1. DO YOU HAVE ANY PHYSICAL OR MENTAL HEALTH CONDITIONS THAT MAY AFFECT YOUR PERFORMANCE FOR THE APPLIED POSITION? | | | | YES |  | NO |  |
| 2. HAVE YOU BEEN REFUSED OR DISMISSED FROM ANY EMPLOYMENT BECAUSE OF HEALTH REASONS? | | | | YES |  | NO |  |
| 3. HAVE YOU PREVIOUSLY OR CURRENTLY UNDERTAKEN ANY MEDICAL OR THERAPEUTIC TREATMENT? | | | | YES |  | NO |  |
| 4. ARE YOU ALLERGIC TO ANY CHEMICALS OR ANY OTHER SUBSTANCES? YOU MAY USE CLEANING CHEMICALS AT WORK. | | | | YES |  | NO |  |
| 5. ARE YOU PREGNENT? | | | | YES |  | NO |  |
| 6. DO YOU HAVE ANY CONTAGIOUS INFECTION / DISEASE? | | | | YES |  | NO |  |
| 7. ANY STRESS RELATED DISORDERS? | | | | YES |  | NO |  |
| 8. DO YOU REGULARLY ATTEND HOSPITAL FOR ANY MENTAL HEALTH CONDITIONS? | | | | YES |  | NO |  |
| 9. ARE YOU RECEIVING ANY MEDICAL TREATMENT? | | | | YES |  | NO |  |
| 10. ANY OTHER HEALTH, PHYSICAL OR MENTAL PROBLEMS? | | | | YES |  | NO |  |
| 11. DO YOU WISH TO DISCUSS ANY ISSUES REGARDING YOUR HEALTH RELATED TO THE APPLIED POST WHICH YOU THINK IT IS A RISK TO CARRY OUT THE JOB ON YOUR OWN OR YOU MAY BE A RISK TO THE VULNERABLE SERVICE USERS? | | | | YES |  | NO |  |
| 12. THE CARE ASSISTANT JOB MAY INVOLVE HOIST AND MANUAL HANDLING SERVICE USERS. WOULD YOU BE ABLE TO DO THIS AFTER APPROPRIATE TRAINING WITHOUT ANY HEALTH RISKS? | | | | YES |  | NO |  |
| 13. ARE YOUR IMMUNISATIONS UP TO DATE? If not, please contact your GP | | | | YES |  | NO |  |
| 14. NUMBER OF DAYS SICKNESS ABSENCE IN THE LAST 2 YEARS: | | | | YES |  | NO |  |
| IF YOU HAVE ANSWERED YES TO ANY QUESTION ABOVE, PLEASE EXPLAIN IN DETAIL BELOW, IF YOU WOULD LIKE TO NOTIFY US OF ANY OTHER HEALTH ISSUE YOU MAY HAVE, PLEASE DO BELOW. | | | | | | | |
|  | | | | | | | |
| SURGERY  NAME |  | SURGERY TELEPHONE  NUMBER |  | | | | |

**DBS FORM AND BANK DETAILS**

If you have subscribed online DBS service, please do not fill DBS form.

We charge £60 for DBS which is none-refundable. We advise you to register your DBS online once you receive it.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| TITLE |  |  | FULL NAME |  |  | |  | | |
| COUNTRY OF  BIRTH |  |  | BIRTH TOWN |  |  | |  | | |
| HAVE YOU CHANGED YOUR BIRTH SURNAME | | | |  | YES |  |  | NO |  |
| **IF “YES”, PLEASE ENTER YOUR SURNAME AT BIRTH (EVEN IF IT IS THE SAME AS THAT ALREADY PROVIDED)** | | | | | | | | | |
| SURNAME AT BIRTH | | | |  |  | |  | | |
| MOTHER MAIDEN NAME | | | |  |  | |  | | |
| DATE YOU CHANGED YOUR SURNAME | | | |  |  | |  | | |
| NATIONALITY AT BIRTH | | | |  |  | |  | | |
| HAVE YOU CHANGED YOUR NATIONALITY SINCE BIRTH? | | | |  | YES |  |  | NO |  |
| IF "YES", WHAT IS YOUR CURRENT NATIONALITY? | | | |  |  | |  | | |
| **PLEASE PROVIDE YOUR ADDRESS HISTORY COVERING THE LAST 5 YEARS INCLUDING OVERSEAS** | | | | | | | | | |
| CURRENT ADDRESS | |  |  |  | CITY | |  | | |
| POSTCODE | |  |  |  | COUNTRY | |  | | |
| FROM DATE | |  |  |  | TO DATE | |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **PREVIOUS ADDRESS 1** | | | |
| ADDRESS |  | CITY |  |
| POSTCODE |  | COUNTRY |  |
| FROM DATE |  | TO DATE |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **PREVIOUS ADDRESS 2** | | | |
| ADDRESS |  | CITY |  |
| POSTCODE |  | COUNTRY |  |
| FROM DATE |  | TO DATE |  |

**BANK DETAILS FOR WAGES**

Wage will be transferred to the mentioned bank account and any error in the information provided will result in loss of pay and the company will not hold any responsibility.

|  |  |  |  |
| --- | --- | --- | --- |
| NAME ON ACCOUNT |  | NAME OF THE  BANK |  |
| ACCOUNT NUMBER |  | SORT CODE |  |
| *By signing this form, you agree.*  *To provide personal care and support to Clients with a wide range of needs, illnesses and disabilities. Assisting with getting up in the morning and going to bed at night, wash, bath, shower, dress, undress, look after their skin, teeth, hair and nails, toileting, continence management, personal hygiene, support with their medication at the agreed level of support , prepare food and drink for the Client, being aware of the Client’s choice, likes/dislikes, nutritional needs and cultural requirements and provide light general household domestic duties, including housework and laundry, as detailed in the care plan or instructed by Management*  *To use manual handling equipment safely and correctly, take responsibility for the safe handling of property and equipment belonging to the Client, maintain good communication and develop effective working relationships with Clients, provide companionship to the Client, actively talking and listening to them about their interests, help the Client to maintain contact with their family and friends, accompany the Client on trips into the community and to ensure as safe as possible*  *the living environment for the Client, whilst respecting the Client’s choice and Rights and payment.* | | | |

**DECLARATION**

|  |  |  |  |
| --- | --- | --- | --- |
| I hereby confirm that the information provided on my application is correct and true to the best of my knowledge and that I have not withheld any information that should be taken into account when offering me work. I understand that providing  false/inaccurate information may result in the termination of employment. | | | |
| NAME |  | **SIGNATURE**  TYPE NAME IF SENDING BY EMAIL |  |
| DATE |  | FOR OFFICE USE (RECEIVED BY) HR SIGNATURE |  |

**WE NEED FOLLOWING DOCUMENTS TO PROCESS YOUR APPLICATION.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1 |  | PASSPORT | 2 |  | VISA OR BIOMETRIC IF YOU DON'T HAVE BRITISH OR EEU PASSPORT. |
| 3 |  | TWO PROOFS OF ADDRESS (UTILITY BILL OR BANK STATEMENTS ETC. ONE LETTER SHOULD NOT BE LATER  THAN 3 MONTHS.) | 4 |  | NATIONAL INSURANCE NUMBER PROOF (NI CARD OR ANY BENEFIT LETTER) |
| 5. |  | ANY OTHER DOCUMENTATION TO SUPPORT YOUR APPLICATION. | 6 |  | TRAINING CERTIFICATES (IF YOU HAVE ANY) |
| 7 |  | P45 (IF THERE IS ANY) IF YOU DON'T HAVE FROM PREVIOUS EMPLOYER, WE WILL GIVE YOU P46 TO FILL. UTR | 8 |  | 2 REFEREE DETAILS. (WE WILL SEND THE FORMS FOR REFEREE TO FILL.) |
| 9 |  | EDUCATION OR QUALIFICATION EVIDENCE/CERTIFICATE | 10 |  | UNIVERSITY LETTER IF YOU ARE OVERSEAS STUDENT |
| 11 |  | PREVIOUS DBS (MUST BE ONLINE REGISTERED, IF NOT WE WILL APPLY ONE FOR YOU AND YOU WILL MEET THE COST OF £85 | | | |

Further employment processing. We will contact your referees and apply for DBS if required. If you are a successful candidate, you will be booked in for a training course which will be either in person or internet based. You will need to go for shadow training. We DONOT pay for any training or shadowing attended to as this is a requirement which you will need to meet.

If you wish to obtain a Care and Training Certificate, there will be a charge for this as you will need to attend a full course