# Ultimate Care & Support Services Ltd

# Application Form

**Guidelines**

Please complete this application form accurately, giving as much details as possible of your skills and experience relating to this job application.

Short listing will be based on the information gathered from the form, read in conjunction with the person specification.

Please ensure the finished form is printed out, signed, dated and returned by the closing date to the address given at the end of this form. We are unable to accept forms returned as email attachments without a signature.

Please either type directly in this form or print out and complete the form in **black ink** and **BLOCK CAPITALS.**

# 

**Post Applied for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Where did you see this post advertised?**

|  |  |  |
| --- | --- | --- |
| Job Centre Plus | |  |
| Newspaper | |  |
| From a friend/family/etc | |  |
| On our website www.ucss.co.uk | |  |
| Online (Gumtree, etc) | |  |
| Other (please state) |  | |

**Are you looking for:**

|  |  |
| --- | --- |
| Full time employment |  |
| Part time employment |  |
| Live-in |  |

**What days/hours would you be available to work?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# 1. PERSONAL DETAILS

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Title (MRS, MISS, MR, DR, or other title)** | | | | | **Date of Birth**  **DD/MM/YYY** | | |
| **Name:** | | | | |
| **Nationality:** | | | | | **National Insurance Number** | | |
| **Address:**  **Postcode:** | | | | | **Home phone:**  **Mobile phone:**  **Email:** | | |
| **Do you hold a current driving license?** | | | **Yes** |  | **Are you willing to travel?** | **Yes** |  |
| **No** |  | **No** |  |
| **What form of transport do you use? Tick where appropriate.** | *Car* | | |  |
| *Walk* | | |  |
| *Bus* | | |  |
| *Cycle* | | |  |
| *Other (state)* |  | | |

**Is there anything concerning your medical history or state of health that you think is relevant to this application? Tick where appropriate.**

|  |  |
| --- | --- |
| **Yes** |  |
| **No** |  |

**How much notice are you required to give your current employer?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. THIS SECTION IS FOR NURSES ONLY**

|  |  |
| --- | --- |
| **NMC pin number/Reg. number** | **NMC/Reg. Expiry date** |
| **Type of registration** *(e.g. RGN, RMN, etc)* |
| **Other professional bodies** |

**Nurses Clinical Details**

**Please tick the clinical areas you have expertise in:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | A&E |  | Cardiac |  | Clinics |  | Community |
|  | Diagnostic Imaging x-ray |  | Elderly \care |  | Endoscopy |  | General Wards |
|  | Gynaecology |  | HDU |  | Health Visitor |  | Homecare |
|  | ITU |  | Learning Disabilities |  | Medical |  | Mental Health |
|  | Midwifery |  | Neonatal |  | NICU |  | Nurse Practioner |
|  | Nursing home |  | Occupational Health |  | ODP |  | Oncology |
|  | Chemotherapy |  | Orthopaedics |  | Paediatric A&E |  | Paediatrics |
|  | Palliative |  | PICU |  | Practice Nurse |  | Prison |
|  | Radiology |  | Recovery |  | Renal |  | Dialysis |
|  | SCBU |  | Surgical |  | Theatre |  | Triage |
|  | Urology |  | Walk in Centre |  | Other*(please specify)* | |  |

**3. GENERAL EDUCATION AND QUALIFICATION**

**Secondary Education**

|  |  |  |  |
| --- | --- | --- | --- |
| **School/College**  **Name** | **Subjects** | **Qualification gained/ grades** | **Date Achieved**  **DD/MM/YYYY** |
|  |  |  |  |

**Further Education and Professional Training**

|  |  |  |  |
| --- | --- | --- | --- |
| **University/College/Institute**  **Name** | **Course & Qualifications obtained** | **Date Achieved**  **DD/MM/YYYY** | **Result** |
|  |  |  |  |

**Other Relevant Training** *(Short courses, In-service training, etc)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Training Provider** | **Title of Course** | **Date Obtained**  **DD/MM/YYYY** | **Result** |
|  |  |  |  |

**Previous Employment**

**Explain any gaps in employment. Please start with most recent or current employer.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Employer** | **Start Date** | **Leave Date** | **Duties** | **Reason for Leaving** |
|  |  |  |  |  |

**Experience, Skills and Personal Qualities** *(continue on blank page, if required)*

|  |
| --- |
| **What qualities do you have which make you suitable for this type of work?** |
|  |

**Emergency Contact Details**

|  |  |
| --- | --- |
| **Name:** | **Relationship to you:** |
| **Address:**  **Postcode:** | **Telephone Number:**  **Email:**  **Home:**  **Mobile:** |

## References

Please give details of two referees. One must be your present or most recent employer. References will only be taken up for the successful candidate. Testimonials or references from friends and relatives are not acceptable.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:**  **Position/Job Title:**  **Address:**  **Telephone Number:**  **Email:** | | | | | **Name:**  **Position/Job Title:**  **Address:**  **Telephone Number:**  **Email:** | | | |
| **May we contact this person prior to the interview?** | | | | | **May we contact this person prior to the interview?** | | | |
|  | **Yes** |  |  |  |  | **Yes** |  |  |
|  | **No** |  |  |  |  | **No** |  |  |
|  |  |  |  | |  |  |  | |

**4. IMPORTANT INFORMATION**

**Immigration Regulations & Eligibility to Work**

|  |  |  |
| --- | --- | --- |
| **Please tick the appropriate box:** | | |
|  | I am eligible to work in the UK and do not require a work permit. |  |
|  | I am already in possession of a work permit to work in the UK |  |
|  | I need to obtain a work permit to work in the UK |  |
|  | If other, please specify in the space below |  |
|  |  | |

**DBS**

Ultimate Care & Support Services Ltd requires the successful applicant to register with the Disclosure and Barring Service (DBS ) if they have not already done so. A satisfactory Disclosure check will be completed prior to appointment. This check is necessary to ensure that UCSS fulfils its legal duties.

If you are successful in your application, the offer of employment will be subject to a satisfactory Enhanced Disclosure Report. UCSS will make a Disclosure application to the disclosure and Barring service which will reveal any past criminal convictions (spent or unspent). Any non-conviction information held locally by the police may also be disclosed should this be considered relevant to the position.

Do you have any criminal convictions? Yes  No 

If yes, please give details on a separate sheet. This should include any spent convictions under Section 4(2) of the Rehabilitation of Offenders Act 1974

**Availability:** Please put the hours that you are available for work each week. UCSS does not work on a flexible hour’s basis. When thinking about this please take into consideration other commitments. E.g. Child care during school holidays etc. All support workers must work alternate weekends. **(This section must be completed)**

Hours: From -

To -

DECLARATION BY APPLICANT

I confirm that the information contained in this application is correct, and that all the relevant information has been given. I agree that I am of good integrity and character and am physically and mentally fit to perform the work that UCSS will provide me. I am fully aware that I will be required to undertake a DBS Check to assess my suitability for the post. I understand that if any of the information provided on this application is later found to be incorrect, my employment may be terminated.

I have read and understood the above statement and have disclosed any criminal convictions that I have.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

By signing and returning this application form, you consent to UCSS using and keeping information about you provided by you – or third parties such as referees – relating to your application or future employment. This information will be used solely in the recruitment process and will be retained for six months from the date on which you are informed whether you have been invited to interview, or six months from the date of interview. Such information may include details relating to ethnic monitoring and disability: these will be used solely for internal monitoring.

Please send the completed application form to:

|  |  |  |
| --- | --- | --- |
| *Care Manager*  *17 Lowry Close, Corby*  *Northants*  *NN18 0QT*  *M:07305009168* | *or* | *Email to*  *febideda@ucss.co.uk* |

**For Office Use Only**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Interview Date | Accept? | Start date | Leave  Date | ID, UNIFORM Returned? |
|  |  |  |  |  |

**HEALTH DECLARATION FORM**

*Private and Confidential*

|  |  |
| --- | --- |
| Name: | Date of Birth (DD/MM/YYYY) |
| Home Address: | |
| Telephone: | Mobile number: |
| General Practioner's (GP) Information  Name:  Address:  Telephone: | |
| Occupational Health Department: | |

To enable us to carry out a health and safety risk assessment to ensure that you are given appropriate work and that you get the right support you need, please tick the appropriate YES/NO box. If the answer to any question is YES then please give details in the space provided.

Have you ever had in your life, including childhood, any of the following?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DESCRIPTION OFF ILLNESS** | | | **YES** | **NO** | **DETAILS/DATE** |
| 1. Heart/circulation Illness or Hypertension | | |  |  |  |
| 2. Blood Disorder e.g. Anaemia, Haemophilia | | |  |  |  |
| 3. Eye Disease/Injury or Defect of Eyesight | | |  |  |  |
| 4. Asthma, Hay Fever | | |  |  |  |
| 5. Bronchitis, Pneumonia, Pleurisy | | |  |  |  |
| 6. Tuberculosis | | |  |  |  |
| 7. Diabetes | | |  |  |  |
| 8. Epilepsy, Frequent Fainting Attacks | | |  |  |  |
| 9. Headaches, Migraines | | |  |  |  |
| 10. Psychiatric Treatment | | |  |  |  |
| 11. Dermatitis, Psoriasis, Eczema, Skin Sensitivities | | |  |  |  |
| 12.Chicken Pox *(if suffered from during childhood, tick YES)* | | |  |  |  |
| 13. Hearing Loss, Frequent Ear Infection | | |  |  |  |
| 14. Hepatitis, Jaundice | | |  |  |  |
| 15. Bladder/Kidney Infection | | |  |  |  |
| 16. Gynaecological Problems, Painful Periods | | |  |  |  |
| 17. Gastric Aiments, Ulcer | | |  |  |  |
| 18. Back Pain, Sciatica or Deformities of the Spine | | |  |  |  |
| 19. Varicose Veins | | |  |  |  |
| 20. Do you have any deformities which affect movement? | | |  |  |  |
| 21. Are you currently receiving any medication from the Doctor? | | |  |  |  |
| 22. Have you ever treated at hospital? | | |  |  |  |
| 23. Are you registered Disable Person? | | |  |  |  |
| 24. Date and Result of last X-ray | | |  |  |  |
|  | | |  |  |  |
| **Have you ever been vaccinated, immunised or tested for/against any of the following:** | | | | | |
| Tuberculosis including BCG | | |  |  |  |
| Heaf, Mantoux or Time | | |  |  |  |
| Rubella (German Measles) | | |  |  |  |
| Poliomyelitis | | |  |  |  |
| Hepatitis B | | |  |  |  |
| Hepatitis B Antibodies (Date and Result) | | |  |  |  |
| HIV | | |  |  |  |
| Tetanus | | |  |  |  |
| Typhoid | | |  |  |  |
| Do you smoke? | | |  |  |  |
| Any other, please state: | |  | | | |
| Height: |  | | | | |
| Weight: |  | | | | |