*Plan Equal Opportunities Employer*

Office Use Only Induction Date:……………..

Start Date:…………………..

.

Employee No:……………….

**APPLICATION FOR EMPLOYMENT**

Haverhill Health Care Agency Ltd seek to recruit employees on the basis of their general suitability for a position and aims to ensure that consideration of age, sex, marital status, disability and racial or ethnic origin should play no part in this process. Your employment application forms a basis for a job being offered. If any information is given incorrectly, falsely or in omission the company reserves the right to terminate your employment without notice.

# Employee Details

Position(s) applied for:…………………………… Date of Application:…………………….

Name:…………………………………………………………………………………………...

Surname Forenames

Address:…………………………………………………………………………………………

House Name/No. Town/City County/District Postcode

Telephone Number N.I.

Number:…………………………….

Registration No:…………………………

E-mail .........................................................

Are you legally eligible for employment in the UK? Yes / No

# Availability

Define exactly what you work availability is. Successful applicants will be offered work based on information set out below. Changes in this information may lead the Company to withdraw the job offer.

Type of employment desired: Full Time / Part Time

Date available for work:………………………. Notice Required at Present Job:……………

Please indicate the number of hours you would prefer to work within the range of hours set out below:

6 - 12 hours 12 - 24 hours 24 - 36 hours 36 - 48 hours Excess of 48 hours

Other Availability:………………………………………………………………………………

Any holiday commitments. Failure to disclose will mean the company may not be able to honour the holiday later:………………………………………………………………………

# Full Employment History

Please attach extra sheets if you require more space – Haverhill Health Care Agency Ltd must have a record of your full employment history)

1. Employer:………………………………….. Job Title:………………………………

Address:………………………………………………………………………………………..

………………………………………………… Telephone No:…………………………

Date Employed: From ……………………. to ……………………………

Salary Reason for

leaving:………………………………

Summarise the nature of the work performed, your job responsibilities and any achievements attained:…………………………………………………………………………………………

………………………………………………………………………………………………….. 2. Employer:………………………………….. Job Title:……………………………… Address:………………………………………………………………………………………..

………………………………………………… Telephone No:…………………………

Date Employed: From ……………………. to ……………………………

Salary Reason for

leaving:………………………………

Summarise the nature of the work performed, your job responsibilities and any achievements attained:…………………………………………………………………………………………

………………………………………………………………………………………………….. 3. Employer:………………………………….. Job Title:………………………………

Address:………………………………………………………………………………………..

………………………………………………… Telephone No:…………………………

Date Employed: From ……………………. to ……………………………

Salary Reason for

leaving:………………………………

Summarise the nature of the work performed, your job responsibilities and any achievements attained:…………………………………………………………………………………………

…………………………………………………………………………………………………..

Have you been dismissed from any previous employment? If so, please state the company and circumstances leading to the dismissal:…………………………………………………………

…………………………………………………………………………………………………. Comments (including explanation of any gaps in employment):

…………………………………………………………………………………………………

………………………………………………………………………………………………….

# Skills and Qualifications

Summarise any special training, skills, licenses, certificates and/or characteristics of yourself that may qualify you as being able to perform job-related functions for the position for which you are applying.

Manual Handling:…………………………….. NVQ Levels:…………………………….

Basic First Aid:………………………………. Basic Food Hygiene:…………………….

Bereavement Counselling:…………………… Police Check:……………………………

Other. Please specify:…………………………………………………………………………...

(Include dates)

…………………………………………………………………………………………………..

…………………………………………………………………………………………………..

*(Please enclose a photocopy of certificates of above training courses).*

# References

List name, address and telephone number of three referees who are able to comment on your honesty, reliability, etc. The referees must not be related to you.

***OFFICE USE ONLY***

# PERSONAL

Name:…………………………………….. *Verbal date:……………………*

*Verbal details:………………….*

Address:………………………………….. *…………………………………*

…………………………………………… *Written sent:……………………*

*Written received:……………….*

Telephone No:……………………………

In what capacity do you know this person:

……………………………………………

# PROFESSIONAL

Name:…………………………………….. *Verbal date:……………………*

*Verbal details:………………….*

Address:………………………………….. *…………………………………*

…………………………………………… *Written sent:……………………*

*Written received:……………….*

Telephone No:……………………………

In what capacity do you know this person:

……………………………………………

# EMPLOYER

Name:…………………………………….. *Verbal date:……………………*

*Verbal details:………………….*

Address:………………………………….. *…………………………………*

…………………………………………… *Written sent:……………………*

*Written received:……………….*

Telephone No:……………………………

In what capacity do you know this person:

……………………………………………

May we contact the above for references at any time? Yes / No Only if we offer you a job? Yes / No

# Criminal Convictions

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 Offender Act, 1974 by virtue of the rehabilitation of offenders Act 1974 (Exemptions) order, 1975. Applicants are, therefore not entitled to withhold information above 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 by the Company. Any information given will be completely confidential and will be considered only in relation to an application for positions for which the order applies.

Please give details of any criminal convictions?:………………………………………………

………………………………………………………………………………………………… Signature:……………………………………… Date:…………………………………….

# Referral Source:

Advertisement Employee Job Centre By walk in by telephone Employment Agency Other:…………………………………

# Declaration

Please list any additional information you would like us to consider:-

………………………………………………………………………………………………….

………………………………………………………………………………………………….

I, the undersigned, being a candidate for the before-named appointment, do hereby declare that the particulars entered by me are, to the best of my knowledge and belief, a true and complete record. I understand that the terms of the Contract of Employment Act, 1972 (as amended) apply to the post.

Signature:……………………………………… Date:…………………………………….

# Medical Details

Confirmation of appointments is subject to satisfactory medical clearance. Our medical advisors will use information requested below solely in order to assess the medical fitness of candidates to carry out the duties of the position. **Confidentiality is guaranteed**.

Name:…………………………………………………………………………………………..

Address:…………………………………………………………………………………………

Date of Birth:…………………. Sex: Male / Female Height:…………. Weight:…………..

Family Doctor:…………………………….. Telephone:………………………………………

Do you normally enjoy good health? Yes / No

Do you smoke? Yes / No If “yes” how many cigarettes per day?…………………………

Do you suffer or have you ever suffered from: If YES supply details:

|  |  |  |
| --- | --- | --- |
| Neck, back pain / slipped disc  Rheumatism | Yes / No  Yes / No | ………………………………………….  …………………………………………. |
| Asthma | Yes / No | …………………………………………. |
| Dizzy spells / faints / blackouts | Yes / No | …………………………………………. |
| Shortage of breath | Yes / No | …………………………………………. |
| Any allergy | Yes / No | …………………………………………. |
| Any skin disorder | Yes / No | …………………………………………. |
| Tuberculosis (BCG) | Yes / No | …………………………………………. |
| Hepatitis | Yes / No | …………………………………………. |
| Angina | Yes / No | …………………………………………. |
| Bronchitis / Emphysema | Yes / No | …………………………………………. |
| Pneumonia / Pleurisy | Yes / No | …………………………………………. |
| Coughing / Spitting blood | Yes / No | …………………………………………. |
| Arthritis or Rheumatism | Yes / No | …………………………………………. |
| Diabetes | Yes / No | …………………………………………. |
| Epilepsy | Yes / No | …………………………………………. |
| High Blood pressure | Yes / No | …………………………………………. |
| Heart disease | Yes / No | …………………………………………. |
| Hernia or Rupture | Yes / No | …………………………………………. |
| Gastric or Duodenal Ulcer | Yes / No | …………………………………………. |
| Typhoid | Yes / No | …………………………………………. |
| Jaundice | Yes / No | …………………………………………. |
| Mental Illnesses | Yes / No | …………………………………………. |
| Nervous breakdown | Yes / No | …………………………………………. |

Have you worked outside of the United Kingdom for more than 3 months in the past 5 years? If so, specify the duration and dates abroad:

…………………………………………………………………………………………………

Details of any time in hospital during the last 5 years, including details of any major operations:

………………………………………………………………………………………………

……………………………………………………………………………………………… Details of any absences from work due to illness for more than a week in the last 5 years.

………………………………………………………………………………………………

………………………………………………………………………………………………

|  |  |  |
| --- | --- | --- |
| Have you been immunised against: |  | If YES, approximate date: |
| Tuberculosis (BCG) | Yes / No | ………………………………………… |
| Measles | Yes / No | ………………………………………… |
| German Measles | Yes / No | ………………………………………… |
| Whooping Cough | Yes / No | ………………………………………… |
| Tetanus | Yes / No | ………………………………………… |
| Polio | Yes / No | ………………………………………… |
| Hepatitis | Yes / No | ………………………………………… |

Please specify any medication you are currently on:

I certify that the above medical information is correct to the best of my knowledge: Signature:……………………………………… Date:……………………………………

# Equal Opportunities Monitoring Form

**Voluntary Information**

In order to monitor the effectiveness of our commitment to equal opportunities it would be helpful if you could complete this form. Completion of the form is not compulsory but should you give details, the information will be used for no other purpose than that is stated in this paragraph.

# Ethnic origin:

African / Afro-Caribbean / Asian (Chinese /S.E. Asian) / Asian (Indian Sub-Continent) / Australasian / European / Polynesian.

Other (please specify):………………………………………………………………………..

**Disabilities**: (specify):…………………………………………………………………………

**Registered Disabled Number** (where relevant):……………………………………………..

Gender: Male:…………… Female:……………

Marital Status: Married:……….. Divorced:…………. Single:……… Separated:……….

Children: How many:……. Ages:…………

Do you have your own transport: Yes / No

What means do you have for getting to and from work?……………………………………….

Signature:………………………………………

Print Name:…………………………………….

Date:……………………………………………