



EQUAL OPPORTUNITY EMPLOYER

APPLICATION FORM - The recruitment process within this organisation has a minimum of two stages.

The completion of this application form is part of stage one. This application will be reviewed and a decision made as to whether to proceed to stage two, the interview, based on this information. If posting then please send to: **Mediatix Health Care Services Ltd, Unit G, Bec 2, Room 15, 50 Wakering Road, Barking, Essex, IG11 8GN Tel: 0203 0111 776 Email: info@mediatrixhealthcare.com**

PLEASE COMPLETE FULLY AND IN CAPITALS

Position applied for:	Care Assistant
Approx. no. of hours wanted	
Full-time / part-time (please circle which you want to work and the times you can work)	Days/ Nights/Mornings/Afternoons/Evenings/Weekends only (please circle which you want to work and the times you can work)
Title : Mr/Mrs/Miss/Ms	Live-in part-time: Yes/No
Surname:	First Name(s):
Live In Carer: Yes/No	DOB:
Previous surnames: (Supply documentary evidence e.g. marriage certificate, deed of name change etc):	Middle name(s):
Marital Status:	Mothers Maiden name:
Current Address:	Post Code:
Moved to this address on (date):	
Previous Address:	Post Code:
Moved to this address on (date) :	
Mobile number:	(will be used with discretion)
Home Telephone number:	Email:
Own Transport (yes/no):	Clean current driving licence:
How long has your licence been held?	Endorsements:
National Insurance Number:	
Current CRB Reference NO:	
P45/46:	

EDUCATION

School/College/University	Examinations Passed/Qualifications gained
	<i>(Please supply copies of certificates)</i>

TRAINING HISTORY/PROFESSIONAL STATUS

Date of Graduation/Qualification	Location/Details	Notes
	<i>(Please supply copies of certificates/membership details)</i>	

SHORT COURSES/TRAINING ATTENDED – Include dates

Subjects		Dates/Location/Level
<i>Please tick and date training undertaken below:</i>		
Moving and Handling	YES/NO	
Health and Safety at work	YES/NO	
Fire Safety	YES/NO	
Safeguarding of Vulnerable Adults	YES/NO	
Safeguarding of Vulnerable Children	YES/NO	
Children Conflict Management	YES/NO	
Complaints Handling	YES/NO	
Lone Worker	YES/NO	
Medication Awareness	YES/NO	
Infection Control	YES/NO	
Basic Life Support	YES/NO	
Dementia Awareness	YES/NO	
Basic Food Hygiene	YES/NO	
Any other		

EMPLOYMENT HISTORY

Current/most recent first. Information must cover the whole of your working life to date. State the reasons for any breaks in employment. Use a separate attached sheet if required; please sign that sheet(s).

Name and address of your most recent/last employer:	Company Name:
Date employed:	From: To:
Position held:	
Reason for Leaving	
Salary/Rate	
Name and address of Employer prior to the employer listed above:	Company name:
Date employed:	From: To:
Position held:	
Reason for Leaving	
Salary/Rate	
Name and address of Employer prior to the employer listed above:	Company name:
Date employed:	From: To:
Position held:	
Reason for Leaving	
Salary/Rate	
Name and address of Employer prior to the employer listed above:	Company name:
Date employed:	From: To:
Position held:	
Reason for Leaving	
Salary/Rate	

HEALTH DECLARATION

Carers/Support workers are required to complete this Health Declaration. Any positive answers will not necessarily affect your application. Please list any medical conditions (past or present) which may affect your ability to do the job.

Occupational Health Assessment	Yes	No	Details
Are you in good health?			
How much time have you lost from work due to illness in the last five years? Please provide details			
Have you ever been treated in hospital for serious illness or surgery? Please give dates			
Have you been treated in hospital during the last 12 months?			
Do you have any physical disabilities that could affect your ability to carry out your assignment?			
Have you ever left, been retired or denied a job on health grounds? Have you ever been denied a driving licence on health grounds?			
Are you a registered disabled person?			
Have you any disability related to your physical or mental health?			
Have you ever suffered from any mental illness, psychological or psychiatric problems?			
Do you get discomfort or pain in the chest or shortness of breath on exercise?			
Have you ever had any problems with your joints, including pain, swelling or stiffness?			
Do you have any difficulty in moving rapidly over short distances?			
Would you have difficulty looking over either shoulder? Do you need to wear glasses or contact lenses?			
Do you have any difficulty with your eyesight which is not corrected by glasses or contact lenses?			

Have you any problems working with Visual Display Units? Have you any problems working in confined spaces/using lifts?			
Do you have any difficulty hearing normal conversation?			
Are you taking any medication that makes you dizzy or drowsy?			
Do you have a medical condition affected by changing sleeping patterns or affecting day time sleep?			
Have you suffered from any alcohol or drug related illness or had an alcohol or drug problem?			
Are you having or awaiting any treatment at the moment?			
What is the date of your last chest x-ray? Are you receiving Medicines, Pills or Tablets from a doctor or on prescription?			
Have you ever suffered from any of the following? Heart Problems/Circulatory Illness/Hypertension High or Low Blood Pressure Diabetes Asthma/Hay fever Bronchitis/Pneumonia/Pleurisy Tuberculosis Epilepsy/Fainting Attacks/Blackouts/Fits/Sudden Collapse Headaches/Migraine Psychiatric Illness/Anxiety/Depression 6 Dermatitis/Skin Sensitivity/Psoriasis/Eczema/Allergies Back Injury/Back Problems/Back Pains Recurrent Infections e.g. Sore Throats/Ear Infections/Eye Infections Hepatitis/Jaundice			
Have you ever been Vaccinated, Immunized or Tested for / against any of the following?	Yes	NO	Details
Tuberculosis incl BCG Heaf, Mantoux or Tine,			
Rubella (German Measles)			
Poliomyelitis			

Hepatitis B			
Hepatitis B Antibodies Date and Result			
HIV			
Tetanus			
Typhoid			
Any Other DOCTOR INFORMATION			

ASSISTANCE WITH INTERVIEW AND ASSESSMENT

<p>Do you require us to make any special arrangements in order for you to participate in the recruitment process? For example, large print forms? Or additional time to complete forms?</p> <p style="text-align: center;">Yes / No</p>	
<p style="text-align: center;">If yes, please give details:</p>	
<p style="text-align: center;">Any offer of employment may be made subject to a satisfactory medical report.</p>	
GP's name:	
Tel no:	
Address:	
<p><i>(Your GP will not be contacted without your permission)</i></p>	

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Full name:	
Relationship:	
Tel no:	Mobile no:
Address:	

IDENTITY DETAILS

CAPACITY TO WORK IN THE UK

Are there any restrictions to your residence in the UK which might affect your right to take up employment in the UK?	Yes / No (<i>delete as appropriate</i>)
If yes, please provide details.	
If you are successful in the application, would you require a work permit prior to taking up employment?	Yes / No (<i>delete as appropriate</i>)

Note: Minimum age legislation dictates that Care workers in general must be 16 years old or older. Please inform your interviewer immediately if you do not meet these specifications.

REFEREES

You must provide references from your two most recent employers/Education. If you are to work in our Hospitals, you will need to provide a clinical lead reference. Please provide an additional character referee or another professional. All will be contacted, therefore kindly inform the referees of the fact that you have used their name. If you are unable to provide the required references, please discuss the matter with us.

Your application will not be processed unless a minimum of 3 referees are provided.

Current or most recent Employer

Full Name:	Job Title
Company Name: Address:	Post Code:
Telephone/Mobile No:	Email:

Previous employer to the one above

Full Name:	Job Title
Company Name: Address:	Post Code:
Telephone/Mobile No:	Email:

CRIMINAL RECORD

Workers of The Agency are subject to the Health and Social Care Act 2008, and will be subject to a Police Record Check through the DBS. Please declare all criminal convictions, whether spent or not, charges, whether proceeded with or not, and warnings and cautions. You will not be eligible for work in a Care setting if you are on the DBS Register(s).

Please declare all criminal convictions, whether spent or not, charges, whether proceeded with or not, and warnings and cautions in the space provided below.

YES / NO

SIGNATURE and DECLARATION – IMPORTANT – READ BEFORE SIGNING

I declare that to the best of my knowledge and belief the information given by me in this application is true, and I understand that the above information forms the basis of my contract of employment. I understand that if any of the information supplied by me is found to be falsely declared, my contract may have been fundamentally breached and my employment may be terminated immediately.

I understand that I cannot be offered a post until a satisfactory response has been received with respect to my DBS Register status, and that should I subsequently be offered a post, that offer will be subject to receipt of two satisfactory references, one of which must be from my previous employer, and that confirmation of the employment will be subject to a satisfactory criminal record check from the DBS. I understand that until a satisfactory response is received from the DBS, and my employment is confirmed, I will be supervised at all times at work, and will not seek or have unsupervised access to vulnerable people. By my signature, I authorise the organisation to request a DBS Register check and a criminal records check from the DBS, on initial employment and at any time during my employment thereafter. I undertake to inform my employer immediately if my DBS Register status or criminal status changes at any time during my employment, such as by being charged with an offence (other than motoring offences), the administering of a warning, criminal conviction, referral to any register of barred Care workers, or withdrawal of any registration required by my employment status.

Signed: _____

Date: _____

Care Standards

In order to guide the interview process, we would like you to indicate your personal philosophy of Care by completing the following statement:

I believe that the purpose of Care from a Care provider is:	
If I was the client using the service from the agency I would be looking for:	
If I am the family member of the client using the service I would want from the agency:	
I believe that I can support a Service User in The Agency because:	
As a member of The Agency Care team I feel valued when:	
I believe that a good relationship between me and the Service User depends on:	
I believe that I learn best when:	
I believe that a good working team is made by:	
I believe that my role in relation to the Service User is:	
My other beliefs and values of relevance to my job are:	

BANK DETAILS

Account Name:	
Account Number:	
Sort Code:	

AUTHORISATION SIGNATURES

Employee:		Date:	
Administration:		Date:	
Registered Provider:		Date:	

Application

By post please send to: Mediatrix Health Care service Ltd, Unit G, Bec 2, Room15, 50 Wakering Road Barking, IG11 8GN Tel: 0203 0111 776/07411152744

By email please send to: info@mediatrixhealthcare.com