Logo

Description automatically generated

**APPLICATION FORM FOR SOCIAL CARE WORKER.**

**Personal Information. CARE ASSISTANT/ CARE WORKER [ ]. SUPPORT WORKER [ ].**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Mr/Mrs/Miss/Ms. | | **Surname:** | | | | | | **First Name**: | | | | | | | | | | | | | |
| Previous Names | |  | | | | Address | |  | | | | | | | | | | | | | |
| **Home Telephone No**: | | |  | | | | |  | | | | | | | | | | | | | |
| **Mobil Telephone No:** | | |  | | | | | **Email address:** | |  | | | | | | | | | | | |
| **Date of Birth**: | | | | **Nationality:** | | | | | **National Insurance No.** | | | |  |  |  |  |  |  |  |  |  |
| **Bank Name:** |  | | | **Sort Code:** | | |  | | **Account No:** | | |  | | | | | | | | | |
| **EDUCATION AND QUALIFICATIONS**. | | | | | | | | | | | | | | | | | | | | | |
| **University/College Attended:** | | | | | **Date attended:** | | | | | | **Result/Qualification obtained**: | | | | | | | | | | |
|  | | | | |  | | | | | |  | | | | | | | | | | |
| **Relevant Trainings:** | | | | | **Date attended:** | | | | | | **Level/Certificate obtained.** | | | | | | | | | | |
|  | | | | |  | | | | | |  | | | | | | | | | | |

**IDENTIFICATION/PVG DISCLOSURE/ SSSC.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **What is your nationality?** |  | | | | **Do you require a work permit?** **Yes [ ]. No [ ].** | | |
| **Are you a British or European citizen? Yes [ ] No [ ].** | | | **Date of issue of permit:** | | | | **Date of expiration:** |
| **PVG NO:** | | | | **Date of issue of PVG:** | | | |
| **Are you registered with the SSSC? Yes [ ] No [ ].** | | **SSSC No:** | | | | **Date of expiration:** | |
| **Do you consent to Caring Spirit Group** **carrying out a check of your PVG and SSSC registration? Yes [ ] No [ ].** | | | | | | | |

**EMPLOYMENT HISTORY.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Please complete **full details of your employment history in the last 5 years**. Specify any gap in employment history. | | | | | | |
| 1.**Name and address of current or last employer:** | | | | | | |
| **Dates Employed [Month/Year]:** | | | **From:** | | | **To:** |
| **Job Tittle:** | | | | | | |
| **Duties & Responsibilities:**  **Reasons for leaving:** | | | | | | |
| **2. Names and address of previous employer:** | | | | | | |
| **Dates Employed [Month/Year]:** | | **From:** | | | **To:** | |
| **Job Tittle:** | | | | | | |
| **Duties & Responsibilities:**  **Reasons for leaving:** | | | | | | |
| 3. **Name and address of current or last employer:** | | | | | | |
| **Dates Employed [Month/Year]:** | **From:** | | | **To:** | | |
| **Job Tittle:** | | | | | | |
| **Duties & Responsibilities:**  **Reasons for leaving:** | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please continue with record of your work history. | | | | |
| 4.**Name and address of current or last employer:** | | | | |
| **Dates Employed [Month/Year]:** | | **From:** | | **To:** |
| **Job Tittle:** | | | | |
| **Duties & Responsibilities:**  **Reasons for leaving:** | | | | |
| **5. Names and address of previous employer:** | | | | |
| **Dates Employed [Month/Year]:** | **From:** | | **To:** | |
| **Job Tittle:** | | | | |
| **Duties & Responsibilities:**  **Reasons for leaving:** | | | | |

**GAPS IN EMPLOYMENT AND REFERENCE DECLARATION.**

|  |
| --- |
| This document has been created to provide sufficient and relevant information in support of staff recruitment process. **Caring Spirit Group** will comply fully with our legal responsibilities under the Regulatory Standards: Conduct of Employment Business’s and Employment Agencies Regulations 2003.In circumstance where gaps in employment cannot be avoided during the recruitment process, we endeavour to fully disclose all information relevant to support our decision to employ. |
| Please you may give reason and circumstance for gaps in employment record if applicable: |
| Please you may give reason for gaps in references if applicable: |

Signature…………………………………………………………… Date………………………………………………………

**EMPLOYMENT HISTORY/ REFERENCE/DISCLOSURE DECLARATION.**

By signing below, I certify that the information on this form is to the best of my knowledge correct. I agree that the information provided will be subject to the rigorous compliance procedure of **Caring Spirit Group** including the receipt of satisfactory employment references and a satisfactory PVG certificate.

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

**REFERENCES.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Please give details of two [2] companies we can contact for an employment reference.** | | | | | |
| **Name of Company:** | | | **Name of Company:** | | |
| **Contact Name:** | | | **Contact Name:** | | |
| **Address:**  **Postcode:** | | | **Address:**  **Postcode:** | | |
| **Telephone No:** | | | **Telephone No:** | | |
| **Email:** | | | **Email:** | | |
| **Please give details of one [1] individuals other than a family member who we can contact for a character reference?** | | | | | |
| **Contact Name:** |  | | | | |
| **Address:**  **Postcode:** | | | | | |
| **Email address:** | | | | **Telephone No** |  |
| **Do you have a next of kin? Yes [ ] No [ ].** | | | | | |
| **Next of Kin Names:** | | **Relationship:** | | | |
| **Contact Address:** | | **Contact Home Telephone No:** | | | |
| **Mobil No:** | | | |
| **Email:** | | | |

**SKILLS AND EXPERIENCE CHECKLIST [ please tick areas you have experience].**

|  |  |
| --- | --- |
| Review and case assessment |  |
| Learning Disability: adult service |  |
| Mental Health challenge: adult service |  |
| Autism/Asperger’s Syndrome [ASD] |  |
| Acquired Brain Injury [ABI] |  |
| Dementia Care Homes |  |
| Community Care |  |
| Learning Disability: adult service |  |
| Hospital |  |
| Mental Health challenge: children service |  |
| Physical Disability |  |
| Children’s Homes |  |
| Supported Tenancy |  |
| Respite Centres |  |
| Day Care Centres |  |
| Prison Service |  |
| Hospices |  |
| Sheltered Accommodation |  |
| Care Homes |  |
| Nursing Homes |  |
| Palliative Care |  |
| Parkinson’s Disease |  |
| Diabetes |  |
| Epilepsy |  |
| Catheter Care |  |
| Stoma Care |  |
| Administration of Medicines |  |
| Challenging Behaviour |  |
| Person Centred Planning |  |
| Record Keeping |  |
| Mental health close monitoring units |  |
| Moving and Handling |  |
| Working with people with eating disorder challenge. |  |

**INDIVIDUAL TRAINING RECORD [APPLICABLE TO SUPPORT WORKER/CARERS].**

|  |  |  |  |
| --- | --- | --- | --- |
| **TOPIC** | **MONTH & YEAR** | **CERTIFICATE PROVIDED YES/NO** | **SIGNED** |
| Moving and Handling Practical |  |  |  |
| Health and Safety |  |  |  |
| Fire Safety |  |  |  |
| Infection Control |  |  |  |
| First Aid |  |  |  |
| Basic Life Support |  |  |  |
| Food Hygiene |  |  |  |
| Medication Administration |  |  |  |
| Epilepsy Awareness |  |  |  |
| Control and Restraint |  |  |  |
| Safeguarding of Vulnerable Adults |  |  |  |
| Dementia Care |  |  |  |
| Management of Violence and Aggression behaviour |  |  |  |
| Other Specialist Subjects |  |  |  |

By signing below, I confirm that the information above is a true record of my training history and I am willing to attend Mandatory Training and Specialist Training as and when required.

Names……………………………………… Signature: …………………… Date: ………………………………………

**HEALTH DECLARATION.**

**Do you have or have you ever had any of the following conditions:**

**YES/NO**

|  |  |
| --- | --- |
| 1. Circulatory problems such as thrombosis or varicose veins? |  |
| 2 Heart problems such as heart attack, angina or high blood pressure? |  |
| 2. Chest problems such as asthma? |  |
| 3. Fainting spells, blackouts or epilepsy? |  |
| 4. Any vision problems not corrected by glasses? |  |
| 5. Ear problems, infections or hearing defect? |  |
| 6. Dermatitis, eczema, psoriasis or any skin problems? |  |
| 7. Joint or back problems, rheumatism or arthritis? |  |
| 8. Any disability? |  |
| 9 Depression/mental illness/eating disorders? |  |
| 10. Diabetes? |  |
| 11. Chickenpox? |  |
| 12. Are you taking any regular medication? |  |
| 13. Do you have any other medical condition that would affect your ability to work? |  |

**DECLARATION:**

I declare that all the above is true to the best of my knowledge. I am willing to provide details of my GP should **Caring Spirit Group** require a medical report.

**Names:** …………………………………………………… **Signature**: ……………………………… **Date**: ……………………………………..

**STAFF WORK ASSESSMENT AND DECLARATIONS.**

**ASSESSMENT FOR NIGHT WORKERS [Do not fill, this is for official use only].**

After careful review of the health questionnaire, our assessment is that

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

□ can work nights

□ cannot work nights

□ should see a doctor or nurse for a medical examination to assess whether he/she can work nights

Signed by Recruitment Manager: …………………………………………… Date: ……………………………………………………………..

**WORKING TIME REGULATIONS 1998 48 HOUR OPT OUT AGREEMENT.**

In accordance with the Working Time Regulations 1998, agency workers of this organisation are not required to work more than 48 hours per week. This is averaged over a 17-week period. This means that an agency worker might work more than 48 hours in one week and less in another during a 17- week period – if the average is not more than 48 hours. Temporary Workers can opt out of this restriction on weekly hours.

By signing this agreement, you agree that you are prepared to work more than 48 hours in any week. This is not a guarantee that you will be offered work more than 48 hours in any week. This is your mutual intention that you are opting out of the restriction. However, you are entitled to give 7 days’ notice if you wish to cancel this agreement at any time. Such notice should be given in writing.

You may choose not to sign this agreement, as failure to sign do not affect your application in anyway.

I hereby agree to opt out of the requirement not to work more than 48 hours per week. I understand that I can give written notice of 4 weeks at any time to terminate this agreement.

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

**DATA PROTECTION AND CONFIDENTIALITY AGREEMENT.**

**DATA PROTECTION AUTHORITY.**

In accordance with the Data Protection Act 1998, I hereby give my permission for my personal information, which may include a completed Application Form; Curriculum Vitae; proof of identification; portrait photograph; PVG disclosure details; references and proof of eligibility to work; to be passed onto a third party, if it is required, as part of an assignment with **Caring Spirit Group.** I also give my permission for **Caring Spirit Group** to create and issue me with an ID card to be carried with me always whilst on an assignment.

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

**CONFIDENTIALITY AGREEMENT.**

I confirm and agree that during assignment with **Caring Spirit Group** and there after I will;

* To hold information relating to the client in the strictest confidence, ensure it is kept safely and securely when not in use.
* I acknowledge that no information is to be removed from the client’s premises without the permission of the Client.
* I acknowledge that the use of computers on client premises is solely for business use and must never be used for personal reasons.
* To use such information only for the work for which it was given.
* Not to disclose to any third party or copy any personal and confidential information regarding a service user or a client except as is required during my duties.
* Any references to service users or clients on any social media network including Facebook and Twitter is strictly prohibited.
* Any breach, either by me or a third party, may result in legal proceedings being bought by the Client against me to recover any losses that have occurred because of a breach of confidentiality.
* Any conversations that compromise the client or the person we support privacy may jeopardise my employment with Caring Spirit Group.

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

**UNIFORM POLICY AND DEDUCTION.**

I accept that I must wear a uniform where required by the client as follows:

**Carers:** a blue tunic or polo shirt as supplied by **Caring Spirit Group,** together with black or navy trousers and black shoes.

**Nurses**: a navy tunic as supplied by **Caring Spirit Group** together with black or navy trousers and black shoes.

I also accept that jeans, leggings, and sandals are **not** acceptable clothing to wear to work.

I accept that I am required to pay for my uniform £15 (for a Healthcare tunic) or £8 (for a polo shirt). I also give permission to **Caring Spirit Group**, to make a deduction from my first wages for the cost of my uniform.

I understand that I must **not** wear my uniform when working for anyone other than **Caring Spirit Group**.

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

**EQUALITY AND DIVERSITY MONITORING FORM.**

We are committed to Equal Opportunities in employment and welcome applications from all sections of the public. Please tick the appropriate box. Any information you provide is for monitoring purposes and will be kept strictly confidential.

Name: ………………………………………………………….. Date of Birth: ……………………………………………………………………………

Sex: Male [ ]. Female [ ].

Status: Single [ ] Married [ ] Divorced [ ] Widowed [ ] Civil Partnership [ ].

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please put a cross (x) in the appropriate box that indicates your cultural background. | | | | |
| A- White | 6 - Mixed | C- Asian or Asian | D - Black or Black | E - Chinese or |
|  |  | British | British | other Ethnic |
| [ ] British  [ ] Irish  [ ] Any other white background, please  Specify: | [ ] White | [ ] Indian | [ ] Caribbean | [ ] Chinese |
| [ ] White & Black Caribbean | [ ] Pakistani | [ ] African  [ ] Any other Black background, please  Specify: | [ ] Any other, please specify: |
| [ ] White & Black  African | [ ] Bangladeshi |
|  | [ ] Any other Mixed background | [ ] Any other Asian  Background, please |  |  |
|  | Please specify: | Specify: |  |  |
|  |  |  |  |  |

Please you may tick the appropriate box to indicate your religious background if you want;

[ ] None [ ] Buddhist [ ] Muslim [ ] Jewish [ ] Christian [ ] Hindu [ ] Sikh [ ] Any other religion, please specify:

Please you may tick the appropriate box to indicate your sexual orientation;

[ ] Heterosexual [ ] Gay/Lesbian [ ] Bisexual [ ] Prefer not to say

**DISABILITY DISCRIMINATION DECLARATION**.

The **Disability Discrimination Act 1995** defines a disabled person as anyone who has had a physical or mental impairment which has a substantial and long-term effect on their ability to carry out normal day to day activities. Taking this definition into consideration do you consider you have a disability? YES [ ] NO [ ]? If YES, please give details.

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

**CRIMINAL CONVICTIONS DECLARATION.**

Have you ever been convicted of a criminal offence which has not been spent under the Rehabilitation of Offenders Act 1974? YES [ ]. NO [ ].

If yes, please state details:

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

Have you ever been convicted of a criminal offence which is classed as spent under the Rehabilitation of Offenders Act 1974? YES/NO. [Please note this question is asked not to discriminate against those who have previous convictions. When applying for a role which requires the Protection of Vulnerable Groups, any convictions which appear that you have not disclosed may jeopardies your suitability for assignment]. If yes, please state details:

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

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

**OCCUPATIONAL HEALTH QUESTIONNAIRE .**

In accordance to CI regulations and guidelines, we require evidence of immunisations and the relevant immunity levels for the diseases listed below.

|  |  |  |
| --- | --- | --- |
| Hepatitis B. Course Date: ……………………………………  Booster Due Date: ………………………………………………………………………  Have you ever had this disease?  Chicken Pox: Yes/ No? If yes specify date of illness: ………………………  MMR/MR/Rubella Immunisation Dates: ……………………………………….  Tuberculosis: Yes/No? If yes, specify date: …………………………………….  Signature: ………………………………………… Date: ………………………………….  GP Names: ……………………………………………………………………………………..  GP Address: ……………………………………………………………………………………  GP Signature & Stamp……………………………………………………………………. |  |  |

**PLEASE KINDLY RETURN COMPLETED APPLICATION FORM TO:**

**Caring Spirit Group**

**29A Kings Street**

**Bathgate**

**West Lothian**

**EH48 1AZ**

**Scotland UK.**  
  
**Email: info@caringspiritgroup.com**