

# TBLOP

## APPLICATION FORM

INSERT  
PASSPORT  
PICTURES HERE

Applicant's First Name:	
Applicant's Middle Name:	
Applicant's Surname:	
Position Applied:	<input type="checkbox"/> Health Care Assistance <input type="checkbox"/> Administrator <input type="checkbox"/> Deputy Manager <input type="checkbox"/> Registered Manager <input type="checkbox"/> Other Specify: _____
Date of Application:	

All Sections of Application have been successfully Completed and Ready to commence work:	<input type="checkbox"/> YES <input type="checkbox"/> NO   OR COMMENTS
Managers Name / or Administrator:	
Signature:	
Start Date:	

## Application Form - Confidential

The information supplied on this application form will be used to evaluate your suitability for employment **TBLOP**. Please read the guidance notes before completing the forms. Once completed, please return the forms to us. If applying by email, please remember to quote the relevant job reference in the subject line of your email.

### Personal information

<b>Position applied for:</b>		<b>Post reference no:</b>	
<b>Last name:</b>		<b>Title (<i>Please specify</i>) e.g. Miss/Ms/Mr/Mrs</b>	
<b>Middle name:</b>		<b>Date of Birth:</b>	
<b>First name(s):</b>		<b>National Insurance Number:</b>	
<b>Previous Surname(s) (if applicable):</b>		<b>Daytime telephone number:</b>	
<b>Do you require a work permit to enable you to work in the UK?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Evening telephone number:</b>	
<b>Address for correspondence:</b>		<b>Mobile number:</b>	
<b>Postcode:</b>		<b>Email:</b>	
<b>Next of Kin Names:</b>		<b>Relationship to the Applicant:</b>	
<b>Next of Kin Address:</b>		<b>Email Address:</b>	
<b>Day Phone:</b>		<b>Evening Phone:</b>	

Please answer the following question if the job/person profile for the job requires this.

Please click or put x on the box that applies to you.

Do you hold a current full driving license?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not applicable for this role <input type="checkbox"/>
If yes is it a clean driving license?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not applicable for this role <input type="checkbox"/>
If no please give details:			

## Education History

Date From			Date to			Secondary School /College/University/ Training Organization	Qualifications Achieved
Month/ Year			Month/ Year				
e.g 01/08/2019			e.g 01/08/2019				
Day	Month	Year	Day	Month	Year		

## Training / Short Courses

Date From			Date to			Secondary School /College/University/ Training Organization	Qualifications
Day/Month/ Year			Day/Month/ Year				
e.g 01/08/2019			e.g 01/08/2019				
Day	Month	Year	Day	Month	Year		

## Membership of Professional Bodies (Nursing and Midwifery Council, General Social Care Council or Other)

Name:		Membership/Status:	
Renewal date:		Number:	



## References

Please ensure that you give a minimum of two references, which cover **at least the last five years of your employment**. The **first** of your references must be your **present employer and your relevant line manager**. If you are unemployed, this should be your last employer, or if this is your first job, your head-teacher or college tutor. Please note that Angel Solutions (UK) Ltd reserves the right to take up references in respect of **any** previous employment paid or unpaid, without further notification to you. \*

### Current Employer

Name:	
Job title:	
Organization address (in full):	
Postcode	
Tel No.:	
Fax No.:	
Email:	
In what capacity do you know them?	

### Previous employer/Character Reference

First Name / surname:	
Job title (if Applicable):	
Organization address (in full):	
Postcode:	
Tel No.:	
Fax No.:	
Email:	
In what capacity do you know them?	

Please click or put x on the box that applies to you.

Can we contact your current employer prior to any conditional offer of employment? Yes  No

\*\*\* Please note that it is Angel Solutions (UK) Ltd policy to obtain references prior to interview for any post in a residential establishment. For all posts, we will ask your referees for comments on your suitability for the post and for employment referees request details on attendance, sickness levels and salary.

### Notice Period

If appointed how soon you could join us:

b) If the answer to the above is yes, are there any reasonable adjustments that need to be made, should you progress beyond this stage?

**Please click or put x on the box that applies to you.**

Yes  No If yes, please give details

### Relevant Experience

Please tell us how your experience, skills and qualifications meet the requirements of the person and job profiles. Please focus your response on the abilities and/or competencies required for the role giving evidence of your experience to date (maximum of 2 A4 sheets). The information you provide will be the basis for shortlisting and you may find it useful to refer to the guidance notes attached before completing this section.

*(Please use continuation sheet)*

### Applicant Declaration

#### Rehabilitation of offenders Act (1974)

Because of the nature of the work for which you are applying, the provisions of Section 4(2) of the Rehabilitation of Offenders Act (1974) do not apply by virtue of the Rehabilitation of Offenders Act (1974) (exceptions) Order 1975. Applicants are therefore required to give information about convictions, which for other purposes are "pent" under the provisions of the Act. Any information given will be completely confidential and will be considered only in relation for positions to which the Order applies.

**Please click on the box that applies to you.**

Have you at any time been convicted of an offence? (y/n)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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IF YES, PLEASE GIVE DETAILS BELOW: -

I declare that the information given above is, to the best of my knowledge, true, I am permitted to work in the UK. I have read, understood and agree to the conditions of work for temporary nurses and carers, of which I have been given a copy. I understand that my registration is subject to the receipt of at least two satisfactory references and a satisfactory result after checking with the Department of Health and/or Police records.

I undertake to inform Angel Solutions (UK) Ltd should I be convicted of an offence in the future. I undertake to inform Authentic & Care Services Ltd, immediately if I am engaged through introduction, including the offer of permanent employment following a temporary assignment. I also acknowledge that this information may form the basis of a computerized personnel system to which I will have access as determined by the Data Protection Act 1984. I agree to respect the confidentiality of Patients and any other information I may have access to all times.

Your registration with Angel Solutions (UK) Ltd can be terminated at any time following unsatisfactory work reports.

Signed:	
Date:	

**Criminal Records, Disqualification & Declaration**

Please refer to covering letter before completing section B, C or D below

**Section A - All applicants**

Are you subject to any current outstanding disciplinary action or legal proceedings? <b>If yes please give details below</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Section B - General posts - Criminal convictions**

Have you ever been convicted of a criminal offence ('unspent' only)? If yes, please give us details of all offences, penalties and dates on the page marked Criminal Record/Disqualification/Other in this application form.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Section C - Criminal record**

Have you ever been convicted of a criminal offence or cautioned? Reprimanded or given a final warning by the police ('spent' or 'unspent')? If yes, please give details of all offences, penalties and dates on the page marked Criminal Record/Disqualification/Other in this application form. <b>If yes please give details below</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

<p>Regulatory body sanctions</p> <p>Are you subject to any sanctions imposed by a regulatory body e.g. GSCC, NISCC, SCCC, CCW, GTC, RCN?</p> <p><b>If yes please give details below</b></p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>Disqualification/Other in this application form.</p> <p><b>Disqualification from working with children or vulnerable adults</b></p> <p>Are you disqualified from working with children or vulnerable adults?</p> <p><b>If yes please give details below</b></p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>

**Section D - Enhanced Disclosures only**

<p>Are you aware of any police enquiries undertaken following allegations made against you that may have a bearing on your suitability for the post?</p> <p><b>If yes please give details below</b></p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>

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**Declaration of Health**

<b>Name:</b>	
<b>Maiden name:</b>	
<b>Home Address:</b>	
<b>Post code:</b>	<b>Phone:</b>

<b>Signed:</b>	
<b>Date:</b>	

Please answer the following questions by ticking the appropriate YES/NO box. If the answer to any questions is YES, then give details in the space provided or on the back of this form. It is your responsibility to inform us immediately if any of the following information changes.  
Have you ever had in your life, including childhood, any of the following?

	<b>Description of illness</b>	<b>Yes</b>	<b>No</b>	<b>Details / Dates</b>
1	Cardiac/Vascular Illness	<input type="checkbox"/>	<input type="checkbox"/>	
2	Eye Disease/ Inquiry or Defect of Vision Not Corrected by Lenses	<input type="checkbox"/>	<input type="checkbox"/>	
3	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
4	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
5	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
6	Epilepsy, Frequent Fainting Attacks	<input type="checkbox"/>	<input type="checkbox"/>	
7	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	
8	Any Degree of hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	
9	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
10	Back pain, Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	
11	Do you have any deformities, which effect movements?	<input type="checkbox"/>	<input type="checkbox"/>	
12	Are you receiving any medication from a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	
13	Have ever been treated for any other serious illness / operation	<input type="checkbox"/>	<input type="checkbox"/>	
14	Are you a registered disable person?	<input type="checkbox"/>	<input type="checkbox"/>	
15	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	
16	I believe that I am medically fit to carry out the duties of the position I have applied for	<input type="checkbox"/>	<input type="checkbox"/>	
17	Are there any reasonable adjustments that an Employer should make to enable you to work?	<input type="checkbox"/>	<input type="checkbox"/>	

**Please give details of last immunization or vaccination for:**

Tuberculosis (We will require a statement of evidence regarding TB immunity i.e. Heaf / Mantoux status)			
	<b>Yes</b>	<b>No</b>	<b>Date (If Known)</b>
Rubella (German Measles)			
Poliomyelitis			
Varicella			
Tetanus			
Hepatitis B			
Any Other E.g. Meningitis			
<b>General Practitioner's Name:</b>		<b>Address or Occupational Health Department:</b>	
<b>Tel:</b>			
Additional Information:			
I declare that all the foregoing statements are true and complete to the best of my knowledge and belief. I hereby give <b>TBLV</b> permission to contact my General Practitioner to obtain further information should it be required.			
Signed:		Date:	

**Specify Working Times**

<b>Full time</b>	<input type="checkbox"/>	<b>Part time</b>	<input type="checkbox"/>	<b>Flexible time</b>	<input type="checkbox"/>
<b>Days</b>	<input type="checkbox"/>	<b>Nights</b>	<input type="checkbox"/>	<b>Weekends</b>	<input type="checkbox"/>

**Type of work**

<b>Care Homes</b>	<input type="checkbox"/>	<b>Residential Homes</b>	<input type="checkbox"/>	<b>Sit in Care</b>	<input type="checkbox"/>
<b>Domestic</b>	<input type="checkbox"/>	<b>Wake in Care</b>	<input type="checkbox"/>	<b>Domiciliary Care</b>	<input type="checkbox"/>
<b>Shopping</b>	<input type="checkbox"/>	<b>Sleep in Care</b>	<input type="checkbox"/>	<b>Live in Care</b>	<input type="checkbox"/>

<b>Hours Available Shift</b>		<b>Time</b>	<b>Other times Please specify</b>
Long day	<input type="checkbox"/>	08:00 am to 20:00 pm	
Morning Shift	<input type="checkbox"/>	07:00 am to 14:00 pm	
Afternoon Shift	<input type="checkbox"/>	14:00 pm to 21:30 pm	
Long night	<input type="checkbox"/>	20:00 pm to 08:00 am	
Other specify	<input type="checkbox"/>		

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## BANK DETAILS

<b>Account Name:</b>	
<b>Bank Name:</b>	
<b>Bank Address:</b>	
<b>Account Number:</b>	
<b>Sort Code:</b>	
<b>Signature:</b>	
<b>Date:</b>	