INSERT PASSPORT PICTURES HERE

APPLICATION FORM

Applicant's First Name:	
Applicant's Middle Name:	
Applicant's Surname:	
Position Applied:	☐ **Health Care Assistance** ☐ **Administrator** ☐ **Deputy Manager** ☐ **Registered Manager** ☐ **Other Specify:** _____
Date of Application:	

All Sections of Application have been successfully Completed and Ready to commence work:	☐ **YES** ☐ **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

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

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 ☐	No ☐	Not applicable for this role ☐
If yes is it a clean driving license?	Yes ☐	No ☐	Not applicable for this role ☐
If no please give details:			

Education History

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

Training / Short Courses

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

Employment Experience

Please give details of your present or most recent employment/voluntary work first and work backwards. Include all periods of unemployment; travel etc, in the space provided so there are no gaps in the record. (If you have additional previous employment, please give details on a separate sheet using the same format).

Date: from (Day/month/year)	Date: to (Day/month/year)	Employer's name and address and nature of business	Job titles and brief description of duties	Current salary or final salary (for last post only) and

Day	Month	Year	Day	Month	Year			**reason for leaving**

Gaps in your employment

Please provide information of any gaps in employment

(Verification of employment gaps will be required if an offer of employment is made)

Date: from (Day/month/year)			**Date: To (Day/month/year)**			**Reason/s for the gap**
Day	Month	Year	Day	Month	Year	

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 TBLOP 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 TBLOP 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 ☐	No ☐

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 TBLOP 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 TBLOP 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? **If yes please give details below**	Yes ☐	No ☐

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 ☐	No ☐

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. **If yes please give details below**	Yes ☐	No ☐

Regulatory body sanctions Are you subject to any sanctions imposed by a regulatory body e.g. GSCC, NISCC, SCCC, CCW, GTC, RCN? **If yes please give details below**	Y e s ☐	No ☐
Disqualification/Other in this application form. **Disqualification from working with children or vulnerable adults** Are you disqualified from working with children or vulnerable adults? **If yes please give details below**	Yes ☐	No ☐

Section D - Enhanced Disclosures only

Are you aware of any police enquiries undertaken following allegations made against you that may have a bearing on your suitability for the post? **If yes please give details below**	Yes ☐	No ☐

Declaration of Health	
Name:	
Maiden name:	
Home Address: **Post code:**	**Phone**:

Signed:	
Date:	

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?

	Description of illness	**Yes**	**No**	**Details / Dates**
1	Cardiac/Vascular Illness	☐	☐	
2	Eye Disease/ Inquiry or Defect of Vision Not Corrected by Lenses	☐	☐	
3	Asthma	☐	☐	
4	Tuberculosis	☐	☐	
5	Diabetes	☐	☐	
6	Epilepsy, Frequent Fainting Attacks	☐	☐	
7	Chicken Pox	☐	☐	
8	Any Degree of hearing Loss	☐	☐	
9	Hepatitis	☐	☐	
10	Back pain, Sciatica	☐	☐	
11	Do you have any deformities, which effect movements?	☐	☐	

12	Are you receiving any medication from a doctor?	☐	☐	
13	Have ever been treated for any other serious illness / operation	☐	☐	
14	Are you a registered disable person?	☐	☐	
15	Mental Illness	☐	☐	
16	I believe that I am medically fit to carry out the duties of the position I have applied for	☐	☐	
17	Are there any reasonable adjustments that an Employer should make to enable you to work?	☐	☐	

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)

	Yes	**No**	**Date (If Known)**
Rubella (German Measles)			
Poliomyelitis			
Varicella			
Tetanus			
Hepatitis B			
Any Other E.g. Meningitis			

General Practitioner's Name: **Tel:**	**Address or Occupational Health Department:**
Additional Information:	
I declare that all the foregoing statements are true and complete to the best of my knowledge and belief. I hereby give **TBLV** permission to contact my General Practitioner to obtain further information should it be required.	
Signed:	Date:

Specify Working Times

Full time	☐	**Part time**	☐	**Flexible time**	☐
Days	☐	**Nights**	☐	**Weekends**	☐

Type of work

Care Homes	☐	**Residential Homes**	☐		**Sit in Care**	☐
Domestic	☐	**Wake in Care**	☐		**Domiciliary Care**	☐
Shopping	☐	**Sleep in Care**	☐		**Live in Care**	☐
Hours Available Shift		**Time**		**Other times Please specify**		

Long day	☐	**08:00 am to 20:00 pm**	
Morning Shift	☐	**07:00 am to 14:00 pm**	
Afternoon Shift	☐	**14:00 pm to 21:30 pm**	
Long night	☐	**20:00 pm to 08:00 am**	
Other specify	☐		

BANK DETAILS

Account Name:	
Bank Name:	
Bank Address:	
Account Number:	
Sort Code:	
Signature:	
Date:	