Caring Focus Ltd
Care for People`s needs

Application Form

The information supplied on this application form will be used to evaluate your suitability for employment. 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.

Job Reference Number	
Job Title	
Department	

Personal Details

Title (*Please specify*) e.g. Miss/Ms/Mrs/Mr	
First Name	
Middle Name	
Surname	
Position Applied	
Application Date	

Caring Focus Ltd
Care for People`s needs

Personal Information

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

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			

Next Of Kin Details

Next Of Kin Names		**Relationship to the Applicant**	
Home Telephone		**Mobile Telephone**	
Address			

Education and Training

Date: From (Month/ Year)	**Date: To (Month/ Year)**	**Secondary School /College/University/ Training Organisation**	**Qualifications**

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 (month/year)	**Date: To** (month/year)	**Employer's name and address and nature of business**	**Job titles and brief description of duties**	**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)

From (month/year)	**To** (month/year)	**Reason/s for the gap**

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 we reserve the right to take up references in respect of **any** previous employment paid or unpaid, without further notification to you.

Current Employer / Organisation	
Name of Employer:	
Job Title:	
Organisation Address (in full):	
Postcode:	
Tel No.:	
Email:	
In what capacity do you know them?	

Previous Employer	
First Name / Surname:	

Job Title: (if Applicable)	
Organisation Address (in full):	
Postcode:	
Tel No.:	
Email:	
In what capacity do you know them? e.g., Manager, Deputy Manager, Senior worker, GP?	

Character Reference	
First Name / Surname:	
Job title: (if Applicable)	
Organisation address (in full):	
Postcode	
Tel No.:	
Email:	
In what capacity do you know them? e.g., Manager, Deputy Manager, Senior worker, GP?	

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.

Write about your experience in health and social care.
Write about your skills or transferable skills
Write about your Qualifications.

TO BE COMPLETED BY EMPLOYEE

I authorized to pay my weekly/ monthly earnings direct into the Bank/Building society Account whose details follow.
I will notify you in writing of any change to these details

Declaration of Health

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	COVID-19	☐	☐	

2	Cardiac/Vascular Illness	☐	☐	
3	Visual defects/ Eye conditions (Including colour-blindness) other than those corrected by glasses?	☐	☐	
4	Asthma, Bronchitis	☐	☐	
5	Tuberculosis	☐	☐	
6	Diabetes	☐	☐	
7	Epilepsy, Frequent Fainting Attacks	☐	☐	
8	Chicken Pox	☐	☐	
9	Any Degree of hearing Loss	☐	☐	
10	Hepatitis	☐	☐	
11	Back pain, Sciatica	☐	☐	
12	Do you have any deformities, which affect movement?	☐	☐	
13	Are you receiving any medication from a doctor?	☐	☐	
14	Have ever been treated for any other serious illness / operation	☐	☐	
15	Are you a registered disabled person?	☐	☐	
16	Mental Illness?	☐	☐	
17	I believe that I am medically fit to carry out the duties of the position I have applied for	☐	☐	
18	Are there any reasonable adjustments that an Employer should make to enable you to work?	☐	☐	
19	Hearing defects / Ear conditions?	☐	☐	
20	Speech or communication problems?	☐	☐	
21	Severe anxiety, depression, other psychiatric disorders?	☐	☐	
22	Paralysis or other psychiatric disorders?	☐	☐	

23	Fainting attacks, blackouts, epilepsy, or fits?	☐	☐	
24	Recurrent headaches, migraines?	☐	☐	
25	Vertigo, giddiness, or tinnitus?	☐	☐	
26	Heart disease, high blood pressure?	☐	☐	

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)			
Vaccination	**Yes**	**No**	**Date or Year of Vaccination**
COVID-19 Vaccination	☐	☐	
Rubella (German Measles)	☐	☐	
Poliomyelitis	☐	☐	
Varicella	☐	☐	
Tetanus	☐	☐	
Hepatitis B	☐	☐	
BCG	☐	☐	
Influenza	☐	☐	
Varicella (Chickenpox)	☐	☐	

General Practitioner

General Practitioner's Name:	
Address or Occupational Health Department:	

I declare that all the foregoing statements are true and complete to the best of my knowledge and belief. I hereby given Caring Focus permission to contact my General Practitioner to obtain further information should it be required.			
Applicant Signature			
Name (Please Print)		**Date**	

Availability Form

Hours of Work

Full time	☐	**Part time**	☐

Type of work

Domiciliary Care	☐	**Live in Care**	☐

Hours Available

Shift		**Time**	**Other times (Please specify)**
Long day	☐	**08:00 to 08:00**	
Morning Shift	☐	**07:00 to 14:30**	

Afternoon Shift	☐	**14:00 to 21:30**	
Night Shift	☐	**20:00 to 08:00**	
Other specify	☐	**09:00 to 23:00**	
Various shifts are available please enquire	☐		

Declaration - to be completed by all applicants.

I confirm the information I have given is correct and complete and that any false statements or omissions may render me liable to dismissal without notice or in some instances, referral to the police.

I understand and agree, that data contained in the application form will be used and processed for recruitment purposes.

I also understand and agree that should I become an employee; the information will also be used for employment related purposes.

I agree to Caring Focus holding and processing this information.

Signature			
Name (Please Print)		**Date**	