



INTERVIEW CHECKLIST FOR APPLICANTS

Applicants must use the checklist below to send original copies of all relevant documents to us. Failure to do so will result in your not being invited for an interview.

- Passport/Birth Certificate/Driver's Licence *
 - Proof of Address (e.g. rent receipt, utility bill)
 - Original certificates/diplomas/NVQ Qualification
 - Certificates of training received in Domiciliary Care
 - 2 passport photographs
 - Bank/Building Society details
 - CRB Enhanced Disclosure check
 - National Insurance card/P45/P60
 - Current Curriculum Vitae (CV)
-

* Only one of these items will be required for the purpose of identification.

For Office Use Only:

- Reference 1 Sent: Received:
- Reference 2 Sent: Received:
- ID Badge Issued:

APPLICATION FORM

(PLEASE COMPLETE IN BLOCK CAPITALS ONLY)

PERSONAL DETAILS

| | | |
|----------|-------------------|------------|
| SURNAME: | TITLE: MR/MRS/MS. | FORENAMES: |
|----------|-------------------|------------|

OTHER NAMES BY WHICH YOU ARE KNOWN:

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

PERMANENT ADDRESS IN THE UK:

POST CODE:

TELEPHONE (HOME):

MOBILE:

E-MAIL ADDRESS:

DATE OF BIRTH (DOB):

NI NO:

MARITAL STATUS:

SINGLE

MARRIED

DIVORCED

WIDOWED

NATIONALITY:

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

IF NOT BRITISH, STATE VISA STATUS (ARE YOU ALLOWED TO WORK IN THE UK?):

YES

NO

DATE OF ENTRY INTO THE UK:

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

LANGUAGES SPOKEN EXCLUDING ENGLISH:

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

NEXT OF KIN:

NAME:

RELATIONSHIP:

ADDRESS:

TELEPHONE:

FOR THOSE APPLYING FOR CARE WORK:

1. PLEASE SPECIFY YOUR AVAILABILITY WITH A CIRCLE:

| MON | | TUES | | WED | | THUR | | FRI | | SAT | | SUN | |
|-----|----|------|----|-----|----|------|----|-----|----|-----|----|-----|----|
| AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM |

2. ARE YOU INTERESTED IN ANY OF THE FOLLOWING JOBS? (PLEASE SPECIFY WITH A TICK)

LIVE-IN
SIT-IN
WAKE-IN
SLEEP-IN

| YES | NO |
|-----|----|
| | |
| | |
| | |
| | |

CODE OF CONDUCT

I have read and understand the terms and conditions of employment and code of conduct for Supreme Care Services employees. I agree to abide by the terms and conditions and uphold the code of conduct at all times.

Signed:.....

Date:.....

CONFIDENTIALITY AGREEMENT

I agree that during the time I am engaged by Supreme care Services Limited to work in any capacity:

- 1. I will not disclose to any person, any information obtained whilst attending an assignment.
- 2. I will hold in trust and confidence for Supreme care Services Limited, all such information, and never use it other than for the benefit of Supreme care Services Limited.

Signed:.....

Date:.....

DISCIPLINARY ACTION

Have you ever been the subject of Disciplinary Action? Yes No

If yes, please give details (use additional pages if necessary):

DECLARATION

If you provide false or misleading information to support your application it will disqualify you from being engaged as a social care worker by Supreme Care Services Limited.

I hereby declare that I have understood and complied with the requirements laid down in the application and I agree that the information given on this form may be used to obtain CRB check on me from the policy authorities.

Signature of Applicant:.....

Date:.....

CONFIDENTIAL HEALTH QUESTIONNAIRE

Please complete this form and return it with the completed application forms. All the information given in this form will be treated as confidential and will not be divulged to a third party without your consent.

Please answer all the following questions by ticking the appropriate box. If your answer to any question is yes, please give further details.

SECTION A

| Have you ever had any of the following? | YES | NO | DETAILS |
|---|--------------------------|--------------------------|---------|
| 1. Eczema, dermatitis or other skin condition | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Discharge or infection of the ears or defects of hearing | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Eye conditions or injuries or defects of sight | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Asthma, hay fever or any other allergic conditions, including Sensitivity to antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Recurrent sore throats or sinusitis | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Tuberculosis, bronchitis or pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Episodes of severe chest pain or breathlessness | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Heart disease or high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Severe headaches | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Fits, blackouts or epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. Gastric or duodenal ulcers or frequent or prolonged indigestion | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12. Hepatitis or jaundice | <input type="checkbox"/> | <input type="checkbox"/> | |
| 13. Prolonged back pain or disc problems | <input type="checkbox"/> | <input type="checkbox"/> | |
| 14. Arthritis or rheumatism | <input type="checkbox"/> | <input type="checkbox"/> | |
| 15. Difficulties in bending or lifting | <input type="checkbox"/> | <input type="checkbox"/> | |
| 16. Kidney or bladder infections | <input type="checkbox"/> | <input type="checkbox"/> | |
| 17. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | |
| 18. Varicose veins | <input type="checkbox"/> | <input type="checkbox"/> | |
| 19. Depression, mental illness or nervous breakdowns | <input type="checkbox"/> | <input type="checkbox"/> | |
| 20. Operations | <input type="checkbox"/> | <input type="checkbox"/> | |
| 21. Accidents (at work or elsewhere) requiring admission to hospital | <input type="checkbox"/> | <input type="checkbox"/> | |
| 22. Any other conditions requiring hospital treatment or investigation As an in-patient or out-patient | <input type="checkbox"/> | <input type="checkbox"/> | |
| 23. Absences from work or school due to ill health during the past year | <input type="checkbox"/> | <input type="checkbox"/> | |

SECTION B

| | YES | NO | DETAILS |
|---|--------------------------|--------------------------|----------------|
| 1. Are you currently taking or receiving any form of medication? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Do you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Are registered disabled or in receipt of a disability allowance? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Do you normally wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. How many days have you lost through sickness in the last year? | <input type="checkbox"/> | <input type="checkbox"/> | |

Name and Address of your General Practitioner:.....
.....Tel. No:.....

Declaration

I know of no health reason that will affect my ability to undertake the duties required of me in the position for which I am applying. All the answers given on this form are true and correct to the best of my knowledge.

Signature of Candidate:.....Date:.....

EQUAL OPPORTUNITIES POLICY

Supreme Care Services Limited is committed to promoting Equal Opportunities. Our policy is to ensure that job applicants and employees receive equal treatment irrespective of their race, colour, gender, age or disablement. By completing all sections of this form you will help us to monitor the effectiveness of our Equal Opportunities policy. All information will be held in strict confidence.

EQUAL OPPORTUNITIES POLICY – MONITORING CHECKLIST

For the purpose of monitoring our Equal Opportunities policy as stated above, please complete the following:

Gender: Male Female

National/Racial Origin:

| | | | | | |
|-------------|--------------------------|-----------|--------------------------|----------|--------------------------|
| Asian | <input type="checkbox"/> | Black | <input type="checkbox"/> | White | <input type="checkbox"/> |
| Pakistani | <input type="checkbox"/> | African | <input type="checkbox"/> | British | <input type="checkbox"/> |
| Bangladeshi | <input type="checkbox"/> | Caribbean | <input type="checkbox"/> | European | <input type="checkbox"/> |
| Indian | <input type="checkbox"/> | British | <input type="checkbox"/> | Other | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | European | <input type="checkbox"/> | | |
| | <input type="checkbox"/> | Other | <input type="checkbox"/> | | |

Disability

Do you consider yourself as having a disability that could affect your day-to-day work? Yes No

If yes, please give details:.....

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Passport Seen Yes No Passport No:

Driver's Licence seen Yes No Driving Licence No:

CRB Reference No: Issue Date:

Level of written English: Poor Fair Good Excellent

Level of spoken English: Poor Fair Good Excellent

NI Confirmed: Yes No

Relevant Immigration Documents seen: Yes No

VACCINATION CERTIFICATES/REPORTS

- 1. TB Yes No
- 2. TETANUS Yes No
- 3. RUBELLA Yes No
- 4. HEPATITIS B Yes No

EXPERIENCE AND EMPLOYMENT HISTORY

PLEASE INDICATE YOUR AREAS OF EXPERIENCE BY TICKING THE APPROPRIATE BOXES:

- | | |
|---|---|
| <input type="checkbox"/> Incontinence Management | <input type="checkbox"/> Managing People with Terminal Illness |
| <input type="checkbox"/> Management of Aggression | <input type="checkbox"/> Managing People with HIV/AIDS |
| <input type="checkbox"/> Managing People with Learning Difficulties | <input type="checkbox"/> Managing People with People with Sensory Loss and Sensory Impairment |
| <input type="checkbox"/> Managing People with Challenging and Anti-social Behaviour | <input type="checkbox"/> Managing People with Physical Disabilities |
| <input type="checkbox"/> Managing People with Depression | <input type="checkbox"/> Managing People with Mental Health Problems Including Dementia |
| <input type="checkbox"/> Managing Specialist Lifting and handling Techniques | <input type="checkbox"/> Managing People with Alcohol and Drugs misuse |

EMPLOYMENT HISTORY (please start with your most recent employment)

PLEASE GIVE DETAILS OF ALL PREVIOUS EMPLOYMENT AND GIVE REASONS FOR ANY GAPS SUCH AS UNEMPLOYMENT, VOLUNTARY WORK, AND LEAVE TO RAISE FAMILY ETC. CONTINUE ON A SEPARATE SHEET IF NECESSARY.

1. EMPLOYER:

NAME AND ADDRESS:

DURATION OF EMPLOYMENT FROM: TO:

POSITIONS HELD:

DUTIES AND RESPONSIBILITIES:

SALARY:

REASON FOR LEAVING:

2. EMPLOYER:

NAME AND ADDRESS:

DURATION OF EMPLOYMENT FROM: TO:

POSITIONS HELD:

DUTIES AND RESPONSIBILITIES:

SALARY:

REASON FOR LEAVING:

FURTHER EDUCATION AND TRAINING:

ORGANIZING BODY:

QUALIFICATION OBTAINED/EXPECTED: DATES: FROM: TO:

REFERENCES

Please provide a minimum of two references, one of which must be from your current or most recent employer.
Please use **block capitals**.

REFERENCE 1

| | |
|--------------|--------------------|
| NAME | TITLE: (MR/MRS/MS) |
| POSITION | |
| ORGANIZATION | |
| ADDRESS | |
| TELEPHONE | |

REFERENCE 2

| | |
|--------------|--------------------|
| NAME | TITLE: (MR/MRS/MS) |
| POSITION | |
| ORGANIZATION | |
| ADDRESS | |
| TELEPHONE | |

HOME OFFICE CIRCULAR HOC 102/88

ALL APPLICANTS MUST ANSWER ALL QUESTIONS ON THIS FORM. FAILURE TO DO SO WILL INVALIDATE YOUR APPLICATION.

In accordance with the above circular, you are required to provide the following information which will be passed on to the police authorities to check the existence and content of any criminal record.

Because of the nature of the work for which you are required, jobs and assignments are exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974 (Exemptions) (Amendments) Order 1986. Applicants are, therefore, not entitled to withhold information about convictions, reprimands or final warnings which, for other purposes, are 'spent' under the provisions of the Act and in the event of employment, any failure to disclose such convictions could result in removal from Supreme Care Services' list of employees.

Please note that this information will only be provided to and checked with the police authorities after a recruitment interview has taken place.

Please answer the following questions using **BLOCK CAPITALS ONLY**:

Have you ever been convicted of a criminal offence, cautioned, sentenced, reprimanded or given a final warning by the police? YES NO

If yes, please provide details:.....

Full Name (Mr/Mrs/Miss/Ms):.....

Present Address:.....

I have lived at the above address since:.....

Previous address (must cover previous five years):.....

Date of birth:

Place of birth:

Your Maiden Name:

Your Height:

Colour of your eyes:

Any other identifying particulars (Please state them):

I consent to the above information being checked with the police and I am aware that any 'spent' convictions will be disclosed.

Signed:.....

Date:.....

DIRECT CREDIT TO YOUR BANK OR BUILDING SOCIETY ACCOUNT

YOUR NAME.....

BANK ACCOUNT DETAILS

NAME OF BANK:.....

BRANCH:.....

SORT CODE:.....

CURRENT ACCOUNT NUMBER:.....

SAVING ACCOUNT NUMBER:.....

BUILDING SOCIETY ACCOUNT DETAILS

NAME OF BUILDING SOCIETY:.....

BRANCH:.....

SORT CODE:.....

CURRENT ACCOUNT NUMBER:.....

SAVING ACCOUNT NUMBER:.....

BUILDING SOCIETY ROLL NUMBER:.....