**Employment Application –** PLEASE COMPLETE FULLY AND IN CAPITALS

**Applicant Information**

**Current Address**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Position applied for: |  |  |  |  |
| Title: | Mr. [ ]  | Mrs. [ ]  | Ms. [ ]  | Miss. [ ]  |
|  First Name: |  | Surname: |  |
| Landline: |  | Mobile: |  |
|  |  |  |  |
| Email: |   |
| DOB: |  | N.I. Number: |  |
| Do you have your own transport? | Yes [ ]  No [ ]  |
| Clean current driving license: | Yes [ ]  No [ ]  |
| How long has your license been held? |  |
|  |  |  |  |
| Address: |  |  |
|  | *House/Flat Number*  | *Street* |
|  |  |  |
|  | *City* | *Postcode*  |
| Moved to this address on (date): |  |

**Next of Kin / Emergency Contact Information**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name: |  | Surname: |  |
|  |  |  |  |
| Address: |  |  |
|  | *House/Flat Number*  | *Street* |
|  |  |  |
|  | *City* | *Postcode* |
| Landline: |  | Mobile: |  |
|  |  |  |  |
| Email: |  |

**Payment Details**

|  |  |
| --- | --- |
| Bank / Building Society Name: |  |
| Branch Address: |  |
|  |  |
| Telephone Number: |  |
| Account Number: |  | Sort code: |  |
| Name on Account: |  |

**Rehabilitation of Offenders Act**

By virtue of the Rehabilitation of Offenders Act 1974 (Exemptions) Amendments Order 1986, the provision of section 4.2 of the Rehabilitation of Offenders Act 1974 does not apply to any employment which is concerned with the provision of health services and which is of such a kind as to enable the holder to have access to persons in receipt of such services in the course of his/her normal duties. Your answer to the following questions should include any spent convictions. This may or may not affect your application.

All Healthcare Assistants will be asked to apply for an Enhanced Disclosure with the Disclosure and Barring Service (DBS) as part of the recruitment and selection process.

|  |
| --- |
| Have you ever been convicted of a criminal offence or received a caution, reprimand or warning? |
| Yes [ ]  | No [ ]  |
| If yes, please give details: |
| Date of conviction: |  |
| Nature of conviction: |  |
|  |  |
|  |  |
|  |  |
| Have you ever been dismissed for a care / support post? |
| Yes [ ]  | No [ ]  |
| If yes, please give details |  |
|  |  |
| Date of dismissal: |  |
| Are you currently suspended, on notice of dismissal, or under investigation from any employer? |
| Yes [ ]  | No [ ]  |
| If yes, please give details: |  |
|  |  |
| Are you currently on sick or maternity leave? |
| Yes [ ]  | No [ ]  |
| Do you have professional / indemnity cover? |
| Yes [ ]  | No [ ]  |
| Do you belong to any other agencies or staff banks? |
| Yes [ ]  | No [ ]  |

Have you had both Covid 19 vaccinations? Yes [ ]  No [ ]

Have you had your Covid 19 booster? Yes [ ]  No [ ]

Have you had the flu vaccination? Yes [ ]  No [ ]

|  |
| --- |
| How did you hear about Ulticare Limited? |
| Local Newspaper [ ]  | Job Centre [ ]  | Internet web page [ ]  | Friends and family [ ]  | Other [ ]  |

**Work Preferences**

|  |
| --- |
| How would you like to work? (tick all that apply) |
| Full time [ ]  | Part time [ ]  | Days [ ]  | Nights [ ]  | Weekdays [ ]  | Weekends [ ]  | Any [ ]  |

**Work Preferences**

You have the option to opt out of the 48-hour working week limitation as laid out in the Working Time Regulations 1998. Please indicate one of the following:

|  |  |
| --- | --- |
| Yes [ ]  | No [ ]  |

**Your Qualifications**

We need to know your practical experience, training and courses/qualifications (i.e. NVQ (, first aid, food hygiene, manual handling, basic life support etc) Please use an extra piece of paper if needed.

|  |  |  |  |
| --- | --- | --- | --- |
| **COURSE NAME** | **DATE COMPLETED** | **INSTITUTION** | **CERTIFICATE?** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| Have you attached a copy of your CV with this application form? |
| Yes [ ]  | No [ ]  |

**Employment History**

|  |  |
| --- | --- |
| When was the last time you had basic life support training? |  |

Please provide details of your full employment history since leaving primary education up to present, starting with your present / latest position and no gaps. Please note, to work within specialist clinical areas, you will need to demonstrate that you have gained a minimum of 1-year experience within the last two years in your specialty. For this you must be able to provide details of at least one professional reference in ‘Section Your References’

**Employment History**

Please use an extra piece of paper if necessary.

|  |  |  |  |
| --- | --- | --- | --- |
| **EMPLOYERS NAME** | **JOB TITLE & DUTIES** | **START DATE & END DATE** | **REASON FOR LEAVING (if applicable)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Assistance with Interview and Assessment**

Do you require us to make any special arrangements for you to participate in the recruitment process? For example, large print forms? Or additional time to complete forms?

|  |  |  |  |
| --- | --- | --- | --- |
| Yes [ ]

|  |  |
| --- | --- |
| If yes, please give details: |  |

 | No [ ]  |

|  |  |  |
| --- | --- | --- |
| Personal Care [x]  | Domestic Care [x]  | Bathing / Shower / Strip Wash [x]  |
| Dressing / Bandaging Wounds [ ]  | Bed Bath [x]  | Housekeeping [x]  |
| Bed Pans / Commodes [x]  | Evaluating Care plans [ ]  | Implementing Care Plans [ ]  |
| Formulating Care Plans [ ]  | Blood Glucose Monitoring [ ]  | Blood Pressure [ ]  |
| Care of Bladder and Bowels [x]  | Changing bedsheet with client on it [x]  |
| Eye Care [ ]  | Challenging behavior (Children)[ ]  | Palliative Care [ ]  |
| Challenging Behavior (Young Adults) [ ]  | Personal Grooming [x]  | Prosthetic Care [ ]  |
| Dementia Care [ ]  | Catheter Bag [x]  | Eating Disorders [ ]  |
| Colostomy Bag [ ]  | Dressing / Undressing [ ]  | Elimination [ ]  |
| Learning Disabilities [ ]  | Pressure Areas [ ]  | Feeding [x]  |
| Hoists [ ]  | Record Keeping [x]  | Mars Sheet [ ]  |
| Mental Health [ ]  | Moving and Handling [x]  | Oral Care [ ]  |
| Report Writing [ ]  | Observations [ ]  | Respiration [ ]  |
| Domiciliary Care [x]  | Live in Care [ ]  | Weight Charts [ ]  |
| Nursing Homes [ ]  |  |  |

**Care and Support Experience**

|  |  |  |
| --- | --- | --- |
| Personal Care  | Domestic Care [x]  | Bathing / Shower / Strip Wash [x]  |
| Dressing / Bandaging Wounds [ ]  | Bed Bath [x]  | Housekeeping [ ]  |
| Bed Pans / Commodes [x]  | Evaluating Care plans [ ]  | Implementing Care Plans [ ]  |
| Formulating Care Plans [ ]  | Blood Glucose Monitoring [ ]  | Blood Pressure [ ]  |
| Care of Bladder and Bowels [x]  | Changing bedsheet with client on it [x]  |
| Eye Care [ ]  | Challenging behavior (Children)[ ]  | Palliative Care [ ]  |
| Challenging Behavior (Young Adults) [ ]  | Personal Grooming  | Prosthetic Care [ ]  |
| Dementia Care [ ]  | Catheter Bag [ ]  | Eating Disorders [ ]  |
| Colostomy Bag [ ]  | Dressing / Undressing [ ]  | Elimination [ ]  |
| Learning Disabilities [ ]  | Pressure Areas [ ]  | Feeding [x]  |
| Hoists [ ]  | Record Keeping  | Mars Sheet [ ]  |
| Mental Health [ ]  | Moving and Handling [x]  | Oral Care [ ]  |
| Report Writing [ ]  | Observations [ ]  | Respiration [ ]  |
| Domiciliary Care [x]  | Live in Care [ ]  | Weight Charts [ ]  |
| Nursing Homes [ ]  |  |  |

**Please tick all that apply**.

**Your References**

Please give the details of at least two referees, with one being from an employer where you have worked for more than 6 months within a healthcare setting.

|  |  |
| --- | --- |
| **Referee 1** |  |
| Employer (most recent) |  |
| Full name |  |
| Job title |
| RAddress |  |
|  | *Street* |
|  |  |  |
|  | *City Postcode* |
| Telephone No. / Fax |  |
| Mobile |  |
| Email |  |
| **Referee 2** |  |
| Full name |  |
| Job title |
| Address |  |
|  | *Street* |
|  |  |  |
|  | *City Postcode* |
| Telephone No. / Fax |  |
| Mobile |  |
| Email |  |

**DECLARATION**

I declare that the information I have given in this application form is complete and accurate in all respects.

I understand that ULTICARE LIMITED need to process the information that I have provided, which constitutes personal and sensitive data, as defined in the Date Protection Act 1998. I hereby give my consent for ULTICARE LIMITED to process such data for Health and Safety and to other parties as required, to assess whether I am suitable for ULTICARE LIMITED assignments.

I also understand that knowingly giving false information will disqualify me from registration with ULTICARE LIMITED.

**How can we contact you?**

Tick all that apply.

|  |  |  |  |
| --- | --- | --- | --- |
| Landline [ ]  | Mobile [ ]  | Text [ ]  | Email [ ]  |

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

**Returning your application**

Please return this form together with a copy of your full CV to.

|  |  |
| --- | --- |
|  **By Post:**THE SATURN CENTERSUITE 10, 2ND FLOORSPRING ROADETTINGSHALLWOLVERHAMPTONWV4 6JX | **Email with solid fill By Email:** info@ulticare.co.uk **Enquiries:** Telephone: 01902492001 |