



Xtra Healthcare

PROVIDING THE HIGHEST QUALITY OF CARE

Xtra Healthcare Ltd

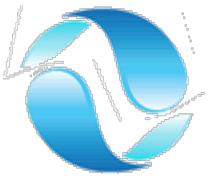
PLEASE COMPLETE FULLY AND IN CAPITALS AND IN BLACK INK ONLY

Position applied for:	
Surname:	First name(s):
Date of Birth:	
Gender:	Male/Female
Do you drive:	Yes/No
Previous surnames (Supply documentary evidence e.g. marriage certificate, deed of name change etc):	
Approx. no. of hours wanted	
Full-time / part-time (please circle which you want to work)	Days/ Nights/Mornings/Afternoons/Evenings/Weekends only (please circle which you are able to work)

Availability:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM							
PM							

Current address:	Telephone No:
Post code:	Moved to this address on (date):



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Previous address Note: For Criminal Record check purposes, addresses covering the five years up to the application date must be supplied. If necessary, use another sheet of paper.	
Post code:	Moved to this address on (date):
Email address:	
Own Transport (Yes/No): How long has your license been held?	Clean current driving license: Endorsements:
Details:	



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EDUCATION

School/College/University	Examinations Passed/Qualifications gained
	<i>(Please supply copies of certificates)</i>

TRAINING HISTORY/PROFESSIONAL STATUS

Date of Graduation/Qualification	Location/Details	Notes
	<i>(Please supply copies of certificates/membership details)</i>	

SHORT COURSES ATTENDED

Subjects	Location



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EMPLOYMENT HISTORY

Please state your last 5 years of employment history (current or most recent first). Information must cover the whole of your working life to date. State the reasons for any breaks in employment. Use a separate attached sheet if required; please sign that sheet(s).

Note: Minimum age legislation dictates that Care workers in general must be 16 years old or older. Please inform your interviewer immediately if you do not meet these specifications. You must provide references from your two most recent employers. Please provide an additional character referee. All will be contacted, therefore please inform the referees of the fact that you have used their name. If you are unable to provide the required references, please discuss the matter with us.



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Date		Name of employer	Position held	Reasons for leaving
Start	Finish			

Reference 1:

Name and address of your most recent/last employer:	
Date employed:	
Nature of business:	



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Position held and reason for leaving:	
Salary / Rate:	

Reference 2:

Name and address of Employer prior to the employer listed above:	
Date employed:	
Nature of business:	
Position held and reason for leaving:	
Salary / Rate:	

Reference 3: *please note this reference will only be used if there are any issues with the other two.*

Name and address of Employer prior to the employer listed above:	
Date employed:	
Nature of business:	
Position held and reason for leaving:	
Salary / Rate:	

Please give details of relevant experience. This may be taken from the work situation, voluntary work, charity or your own home. Please use separate sheet if insufficient space is available.

ASSISTANCE WITH INTERVIEW AND ASSESSMENT

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

Yes / No



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If yes, please give details:

Any offer of employment may be made subject to a satisfactory medical report.

GP's name:

Tel no:

Address:

(Your GP will not be contacted without your permission)

NEXT OF KIN

Please provide us with updated details of any Kin you wish to be contacted in case of an emergency.

Full name:



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Relationship:	
Tel/Phone no:	
Address:	

IDENTITY DETAILS

Nursing and Midwifery Council PIN number:	(Nurses only)
National Insurance Number:	(all applicants)

CAPACITY TO WORK IN THE UK

Are there any restrictions to your residence in the UK which might affect your right to take up employment in the UK?	Yes / No (<i>delete as appropriate</i>)
If yes, please provide details.	
If you are successful in the application, would you require a work permit prior to taking up employment?	Yes / No (<i>delete as appropriate</i>)

CRIMINAL RECORD

Workers of The Agency are subject to the Health and Social Care Act 2008, and will be subject to a Police Record Check through the DBS. Please declare all criminal convictions, whether spent or not,



charges, whether proceeded with or not, and warnings and cautions. You will not be eligible for work in a Care setting if you are on the DBS Register(s).

Please declare all criminal convictions, whether spent or not, charges, whether proceeded with or not, and warnings and cautions in the space provided below.

SIGNATURE and DECLARATION – IMPORTANT – READ BEFORE SIGNING

I declare that to the best of my knowledge and belief the information given by me in this application is true, and I understand that the above information forms the basis of my contract of employment. I understand that if any of the information supplied by me is found to be falsely declared, my contract may have been fundamentally breached and my employment may be terminated immediately.

I understand that I cannot be offered a post until a satisfactory response has been received with respect to my DBS Register status, and that should I subsequently be offered a post, that offer will be subject to receipt of two satisfactory references, one of which must be from my previous employer, and that confirmation of the employment will be subject to a satisfactory criminal record check from the DBS. I understand that until a satisfactory response is received from the DBS, and my employment is confirmed, I will be supervised at all times at work, and will not seek or have unsupervised access to vulnerable people.

If the post I have applied for is as a Registered Nurse, my confirmation of employment will also be subject to a satisfactory search of the Nursing and Midwifery Council records and registers. By my signature, I authorize the organization to request a DBS Register check and a criminal records check from the DBS, on initial employment and at any time during my employment thereafter. I undertake to inform my employer immediately if my DBS Register status or criminal status changes at any time during my employment, such as by being charged with an offence (other than motoring offences), the administering of a warning, criminal conviction, referral to any register of barred Care workers, or withdrawal of any registration required by my employment status.

Signed: _____ **Date:** _____



EQUAL OPPORTUNITIES MONITORING FORM

Xtra Healthcare Ltd offers work and appoints employees based on merit and does not discriminate unfairly in recruitment or any other treatment. **Any information that you provide on this form is strictly confidential and is for monitoring purposes only (it will not be used as part of the selection process).**

Forename(s): _____ Surname: _____

RELIGION/BELIEF

Please tick the most appropriate box below

<input type="checkbox"/> Buddhist	<input type="checkbox"/> Christian
<input type="checkbox"/> Hindu	<input type="checkbox"/> Jewish
<input type="checkbox"/> Muslim	<input type="checkbox"/> Any other religion (please state)
<input type="checkbox"/> Sikh	<input type="checkbox"/> No religion/belief

ETHNIC ORIGIN

Please tick the most appropriate box below.

<input type="checkbox"/> White British	<input type="checkbox"/> Chinese
<input type="checkbox"/> White Irish	<input type="checkbox"/> Other Asian Background
<input type="checkbox"/> Other White Background	<input type="checkbox"/> Mixed: White & Black Caribbean
<input type="checkbox"/> Black or British Black Caribbean	<input type="checkbox"/> Mixed: White & Asian
<input type="checkbox"/> Black or British Black African	<input type="checkbox"/> Other Mixed Background
<input type="checkbox"/> Other Black Background	<input type="checkbox"/> Other Background



<input type="checkbox"/> Asian or Asian British: Indian	If you have ticked "Other" please provide us with further details below:
<input type="checkbox"/> Asian or Asian British: Bangladeshi	
<input type="checkbox"/> Asian or Asian British: Pakistani	

DISABILITY

The Disability Discrimination Act 1995 (DDA) defines a disability as **“A physical or mental impairment which has substantial and long-term adverse effect on a person’s ability to carry out normal day to day activities”**. (In such cases long term is regarded as more than 12 months). Anyone who is diagnosed with HIV, cancer or Multiple Sclerosis is immediately treated as disabled under the DDA. We do not discriminate based on the grounds of a person’s disability and we are strongly committed to providing appropriate support for staff/students with disabilities.

Do you consider that you have a disability/health concern which falls under the Disability Discrimination Act?

Yes No

Please tick the nearest description of your disability/disabilities below:

<input type="checkbox"/> Specific Learning Disability (e.g. Dyslexia)	<input type="checkbox"/> Spectrum Disorder or from head injury
<input type="checkbox"/> Deaf/Serious hearing impairment	<input type="checkbox"/> Mental health conditions (including depressive illness)
<input type="checkbox"/> Blind/Serious visual impairment	<input type="checkbox"/> General Learning Disability (e.g. Down Syndrome)
<input type="checkbox"/> Cognitive Impairment (e.g. Autistic)	<input type="checkbox"/> Long standing illness/health condition (e.g. epilepsy, asthma or diabetes)
<input type="checkbox"/> Wheelchair user or other physical/mobility impairment	<input type="checkbox"/> Any other not mentioned (please state below)

Without knowledge of your disability, it may be difficult to fully provide support for your needs and make the necessary adjustments. **Information disclosed by the applicant regarding your**



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disability and/or additional needs will be handled with the strictest confidentiality. For any further support please contact Lizzy Ringisai on 01604215530-33.

HEALTH DECLARATION

Please tick the most appropriate boxes below.

	General Health Questions	Yes	No
1.	Cardiovascular disease (e.g. chest pain, heart attack, blood clots or high blood pressure).		
2.	Respiratory disease (e.g. Emphysema, Asthma, Chronic Bronchitis or other).		
3.	Liver/Gallbladder disease (e.g. gallstones, Jaundice, Hepatitis or other).		
4.	Gastrointestinal disease (e.g. Peptic ulcer, Gastrointestinal bleeding).		
5.	Contagious blood disease (e.g. HIV, Hepatitis B/C or other).		
6.	Kidney disease		
7.	Diabetes		
8.	Rheumatoid Arthritis		
9.	Allergies (e.g. drug, food, material allergies, hypersensitivity or other).		



10a.	Previous general anesthesia/local anesthesia?		
10b.	If Yes, did you experience any adverse reactions?		
11.	Mental illness (e.g. have you been admitted to a psychiatric hospital)?		
12.	Do you smoke? (If yes, please state your daily consumption of tobacco, e.g. number of cigarette).		
13.	Do you consume alcohol daily?		

Are you currently taking any medication?

Yes No

Name of Medication(s):

Dosage:

Further Details:

WORKING TIME DIRECTIVE CONSENT



I agree to opt out of the working time directive (1998) and hence I am willing to work more than 48 hours per week.

Signature _____

Print Name _____

Date _____

CRB/DBS PRECHECK FORM

Full Name(s):

Mother Name: -----

Maiden Name:

Any other Names Used

1 From.....To

2 From.....To.....

3 From..... To.....

Please provide us with any name changes you many have had and when you changed it, even if you haven't changed your name please state the year you were married/divorced if applicable.

Date of Birth: _____

Town & Country of birth: _____

ADDRESS HISTORY (5 YEARS)

*If you have lived in your home for 5 years or more only one address is needed (note: this **address history section must have no gaps, as this will delay your application**).*



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1.

Month & Year moved in: _____

House number/Building name: _____

Road Name: _____

City: _____

County: _____

Country: _____

Post Code: _____

2.

Month & Year moved in: _____

House number/Building name: _____

Road Name: _____

City: _____

County: _____

Country: _____

Post Code: _____

3.

Month & Year moved in: _____

House number/Building name: _____

Road Name: _____

City: _____

County: _____

Country: _____

Post Code: _____

4.



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Month & Year moved in: _____

House number/Building name: _____

Road Name: _____

City: _____

County: _____

Country: _____

Post Code: _____

5.

Month & Year moved in: _____

House number/Building name: _____

Road Name: _____

City: _____

County: _____

Country: _____

Post Code: _____



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BANK DETAILS

Full Name(s):

Account Name: _____

Account Number: _____

Sort Code: _____

National Insurance Number: _____



UNIFORM LOG

At Xtra Healthcare Ltd our policy is that employees are required to wear uniform when at work (as a Health and Safety regulation). Expense of the uniform is wholly met by the employer, therefore there is no charge to the employee. However on termination of employment, one is required to return the uniform in good condition, failure to do so will result in you incurring a £15 wage deduction on your final pay.

UNIFORM SIZING

As part of our policy, here at Homepoint Healthcare we strive to meet all of our employees clothing needs, as we want to promote a professional image, so we have a wide range of sizes available for selection.

Tunic		Polo Shirts	
<input type="checkbox"/> 14	<input type="checkbox"/> 22	<input type="checkbox"/> SMALL	<input type="checkbox"/> XXL
<input type="checkbox"/> 16	<input type="checkbox"/> 24	<input type="checkbox"/> MEDIUM	<input type="checkbox"/> XXXL
<input type="checkbox"/> 18	<input type="checkbox"/> 26	<input type="checkbox"/> LARGE	
<input type="checkbox"/> 20	<input type="checkbox"/> 28	<input type="checkbox"/> XL	

Date Issued: _____

Issued by: _____

Date Returned: _____

Received by: _____