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| YOUR PERSONAL DETAILS | |
| Title: | |
| Surname: | |
| First Name: | |
| Preferred name to be known by: | |
| Address: | |
| Post code: | |
| Mobile Number: | |
| Daytime Phone Number: | |
| Email Address: | |
| Do you hold a current UK Driving Licence? YES NO | |
| State the position applied for  HCA RGN RMN Support Worker Senior Support Worker  Care Assistant Deputy Manager Administration | |
| RIGHT TO WORK DETAILS | |
| N.I Number: | D.O.B: |
| Your Nationality: | |
| I am eligible to work in the UK and do not require a work permit: YES NO | |
| I am already in possesion of a work permit to work in the UK: YES NO | |

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| YOUR PROFESSIONAL CONDUCT | | | |
| Have there been any proceedings of medical negligence or professional misconduct against you and have you ever been suspended or dismissed? YES/NO  If YES please supply details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| REHABILITATION OF OFFENDERS ACT | | | |
| Due to the nature of the work for which you are applying, section 4(2) and further orders made by the secretary of state under the provision of this section of the rehabilitation of offender’s act (1974) (exceptions) order 1975 applies. Applicants are therefore required to give information about convictions which for other purposes are ‘spent’ 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. | | | |
| 1. | Do you have any convictions, cautions? (if YES please give details) | YES | NO |
| 2. | Have you ever had disciplinary action taken against you? (If YES please give details) | YES | NO |
| 3. | Are you at present the subject of criminal charges or disciplinary action? (If YES please give details) | YES | NO |

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| Employment History | | | |
| Please write details of all your employment for a period of at least the last 5 years, to include all nursing agency memberships, starting with the most present employment. Please include reasons for gaps | | | |
| Employer Name & Address | From | To | Reason for leaving |
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| EDUCATION AND TRAINING | | | | |
| Organising Body | Course Taken | From  (dd/mm/yy) | To  (dd/mm/yy) | Attainment |
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| YOUR NEXT OF KIN |
| Name of Next of Kin: |
| Relationship: |
| Phone Number: |
| Address: |

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| REFERENCE DETAILS |
| Please supply us with two references. One must be from your present or most recent employer (may we contact your referees YES/NO) |
| REFERENCE ONE |
| NAME: |
| POSITION: |
| WORK ADDRESS: |
| WORK EMAIL: |
| TELEPHONE: |
| FAX: |
| REFERENCE TWO |
| NAME: |
| POSITION: |
| WORK ADDRESS: |
| WORK EMAIL: |
| TELEPHONE: |
| FAX: |

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| CONFIDENTIALITY |
| I hereby declare that at no time will I divulge to any person, nor use of my own or any other person’s benefits, any confidential information in relation to Courtesy Healthcare or any of its respected service users or in a relation to any of their employers, business affairs, transactions or finances which I may acquire during the term of my agreement and / or engagement with Courtesy Healthcare. |

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| DATA PROTECTION |
| I agree that Courtesy Healthcare retains the right to hold this registration and any other data required to process it and to pass on to any authorized third party the details held within, also to retain these details for as long as reasonably necessary in accordance with the General Data Protection Regulation (GDPR) 2018 |

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| HEALTH AND SAFETY |
| Each worker has a responsibility at the start of their shift to become familiar with the service user’s general policies including without limitation. |

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| HEALTH ASSESSMENT | | |
| **If your answer to any of these questions is YES or if you are currently taking any medication, please provide details in the space below** | YES | NO |
| Have you had any medical problem in the past which has prevented you from working at night? |  | No |
| Are you diabetic? |  | Yes |
| Are you subject to angina, or other heart problems which may affect your fitness? |  | No |
| Are you suffering from any circulatory problems which affect your activities? |  | No |
| Have you had stomach ulcers in the past, or under treatment at present? |  | No |
| Have you had any continuing bowel problem, for instance following major surgery? |  | No |
| Do you have any chronic chest problem such as asthma, emphysema or bronchiectasis? |  | Yes |
| Do you have any disability affecting mobility which will cause difficulties in arranging night work? |  | No |
| Are you having specialist care requiring your attendance at hospital clinics for treatment? |  | No |
| Do you have any other health problem which affects your fitness for night work? |  | No |
| Are you taking any medication to a strict timetable? |  | Yes |

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| WORKING TIME REGULATION | |
| For the purposes of the Working Time Regulations 1998, I consent to work in excess of an average of 40 hours per week. I understand that I may withdraw this consent by giving Courtesy Healthcare not less than 3 months’ notice at any time in addition I also consent to work in excess of a maximum number of hours permitted to work at night under the directive, please note you are under no obligation to sign either declaration | |
| PRINT YOUR NAME: |  |
| SIGNATURE: |  |
| DATE: |  |

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| **PLEASE READ THE COMPLETED REGISTRATION BEFORE SIGNING** | |
| I declare that by signing this form I am stating that I am legally entitled or allowed to work in the United Kingdom, with or without necessary permission from the Home Office or any other relevant authority If I have secured permission to work, I have included copies of all documentation. I also acknowledge that if it is found that I am working without relevant permission my employment will be terminated with immediate effect and all details passed to the relevant authorities. I agree that DALCHI HEALTHCARE retains the right to hold this registration form and any other data required to process it and pass onto any authorized third party and the details held within. I also agree to use all reasonable efforts to assist to comply with the Data Protection Act 1998 | |
| DOCUMENTS REQUIRED | |
| * Two passport photographs * DBS * Proof of National Insurance Number * Right to work documents * Proof of ID | |
| BANK DETAILS (FOR PAYROLL PURPOSES) | |
| Bank Name |  |
| Account Name |  |
| Acc. Number |  |
| Sort Code |  |
| PRINT NAME: |  |
| SIGNATURE: |  |
| DATE: |  |

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| PERSONAL DECLARATION |
| * I confirm that the information given in this registration is, to the best of my knowledge, true and that an attempt to gain placement by deception is a criminal offence. * I am permitted to work in the UK. * I understand to inform Courtesy Healthcare immediately should I be convicted of any offense in the future and will review all information contained in any Enhanced DBS. * I agree to respect the confidentiality of service users and any other information I may have access to at all times. * I agree that my personal details, including my DBS Enhanced Disclosure may be viewed by third party auditors and potential employers. * I give permission for the processing of the personal data contained in this form for employment for employment purposes. * I understand that Courtesy Healthcare cannot guarantee work that they have non responsibility to pay for no matter the situation. * I understand that my registration is subject to a receipt to at least two satisfactory references and Enhanced Disclosure from DBS, I give my permission to Courtesy Healthcare to carry out a status check using the Update Services on my DBS certificate and may be asked to provide a written statement regarding any information revealed on my DBS certificate.  |  |  | | --- | --- | | PRINT NAME: |  | | SIGNATURE |  | | DATE: |  | |

**Old Courthouse, St peters Churchyard**

**Derby, DE1 1NN**

**Email: admin@courtesyhealthcare.co.uk**

**Tel: 01332480268**