



PROFESSIONALS
CARE WITH DIGNITY AND EXCELLENCE

Email: info@westnahprofessionals.co.uk

Web: www.westnahprofessionals.co.uk

1 West Regent Street

Glasgow

G2 1RW

Tel: 0141 468 8670

CARE STAFF APPLICATION FORM

Please use CAPITAL LETTERS throughout.

PERSONAL DETAILS

Title:

Forename:

Middle Name:

Surname:

Maiden Name:

Date of Birth:

Male Female

Age:

National Insurance:

Address:

City/Town:

Country:

Postcode:

Home Telephone:

Mobile Phone:

Email Address:

Preferred Contact Method:

Are you willing to accept:

Morning calls Evening Calls

Work Status:

Passport Number:

Nationality:

Eligibility to Work in UK:

Birth Certificate No:

Home office Letter Ref:

Place of Study (if Student):

Valid Driving License:

Yes No

Endorsements:

Access to transport:

Yes No

Willing to Travel for Work:

Yes No

Registered Disabled:

Yes

No

Disabled Registration Number:

EDUCATIONAL/PROFESSIONAL TRAINING

Qualification	Place of Study	Date Obtained

Please tick the following specialities which apply, including relevant experience time.

Specialty	>6 Months Experience	6-12 Months Experience	1-2 Years Experience	< 2 Years Experience
Children				
Elderly				
Adolescents				
Residential Care				
Nursing Homes				
Hospitals				
Physical Disability				
Mental Disability				
Learning Disability				

EMPLOYMENT HISTORY

Please give details of your past 5 years of continuous work history giving reasons(s) for any breaks in employment.

From / /

To / /

Employer Name:

Address:

Telephone Number:

Main Contact:

Job Title:

Grade (if applicable):

Full-Time or Part-Time:

Salary:

Main Responsibilities:

Reason for Leaving:

From / /

To / /

Employer Name:

Address:

Telephone Number:

Main Contact:

Job Title:

Grade (if applicable):

Full-Time or Part-Time:

Salary:

Main Responsibilities:

Reason for Leaving:

From / /

To / /

Employer Name:

Address:

Telephone Number:

Main Contact:

Job Title:

Grade (if applicable):

Full-Time or Part-Time:

Salary:

Main Responsibilities:

Reason for Leaving:

From / /

To / /

Employer Name:

Address:

Telephone Number:

Main Contact:

Job Title:

Grade (if applicable):

Full-Time or Part-Time:

Salary:

Main Responsibilities:

Reason for Leaving:

HEALTH DECLARATION

I declare that I do not suffer from any illness that may hinder my performance as a Care Assistant.

GP Surgery Name:

Address:

Telephone Number:

Email:

Applicant Signature:

WORK PREFERENCE

Please specify the area of care work you are interested in, tick all relevant boxes.

NHS

Private Hospital

Nursing Home

Residential Home

Please Specify:

Short-term

Long-term

Please specify your preferred days/times of work, tick all relevant boxes.

Day Shift (Mon-Thurs)

Night Shift (Mon-Thurs)

Day Shift (Friday)

Night Shift (Friday)

Day Shift (Sat-Sun)

Night Shift (Sat-Sun)

Bank Holidays

Dates of any current booked holidays:

Date that you can start work:

REFERENCES

Please provide the names and addresses of your two most recent employers who have the ability to comment on your work character and experience.

Name of Reference:

Company Name:

Address:

Position:

Postcode:

City/Town:

Country:

Telephone No:

Email Address:

Start Date: / /

End Date: / /

Name of Reference:

Company Name:

Address:

Position:

Postcode:

City/Town:

Country:

Telephone No:

Email Address:

Start Date: / /

End Date: / /

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact:

Relationship:

Address:

Post Code:

Country:

Home Telephone:

Mobile Number:

Email Address:

WORKING TIME REGULATIONS

I have read and understood the working time regulations and I hereby consent that the working time limit shall not apply to my assignments.

Print Name:

Signed:

Date: / /

FINAL STATEMENT

I declare that the information provided on this application is true to the best of my knowledge. I have read the terms and condition of engagement and agree to comply with the current Health and Safety at Work Act. I understand that my appointment is subject to the receipt of two satisfactory references and it subject to Enhanced CRB Disclosure. West NAH Professionals is free to make any other enquiries thy may find necessary relating to my application. I agree to respect the confidentiality of patients and clients and any other information I may have access to.

Signed:

Date: / /