

PROFESSIONALS CARE WITH DIGNITY AND EXCELLENCE

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Glasgow

G2 1RW

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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 No
Endorsements:	
Access to transport:	Yes No
Willing to Travel for Work:	Yes No No

isabled Registration Numbe			
E	DUCATIONAL/PROFESSIONAI	. TRAINING	
Qualification	Place of Study	Date Obtained	

Experience

Experience

Experience

Experience

Children
Elderly
Adolescents
Residential Care
Nursing Homes
Hospitals

Physical Disability Mental Disability Learning Disability No

Yes

Registered Disabled:

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 / /	T- /
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:

REHABILITATION OF OFFENDERS ACT 1974

Because of the nature of the work for which you are applying, this post is exempt from the provisions of section 4.2 Rehabilitation of Offenders Act 1974 (Exemption Order 1975).

Applicants are therefore not; entitled to withhold information about convictions, which for other purposes are 'spent' under the provision of the Act in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action.

Information provided will be kept confidential and use in relationship to the post applied for.

Have you ever been convicted of a criminal <i>If yes, please specify:</i>	offence?	Yes	No	
Do you have any spent or unspent conviction of the second	ons?	Yes	No	
Have you instigated an enhanced disclosure I hereby consent to West NAH Professionals various data sources in order to verify my in	s LLP checkir dentity and p	ng the details I process this app	olication. Thes	-
used to assist other organisations such as C Signature:	.RB, ana in id Date:	ientity purpose /	/	

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 STAT	TEMENT			
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:	,	/	
Signeu.	Date.	,	/	