



APPLICATION FORM

Domiciliary Care Agency

Complete in BLOCK CAPITALS

Position Applying For

Position _____ **Available to Start** _____

Type of Work Full Time Part Time Bank Days Nights

Where did u hear about this position?

Word of Mouth Job Centre Internet Local Press
Leaflet Recruitment Agency National Press Other

Are you involved in any activity which might limit your availability to work or your working hours? Yes No

If YES, please give full details _____

Personal Details

Title Mr Mrs Miss Ms

Forename(s) _____

Surname _____

Address _____

Post Code _____

Home Tel _____ **Mobile** _____

Email _____

National Insurance _____ **Nationality** _____

Are you eligible to work in the UK? Yes No

Please indicate your eligibility: UK Citizen Visa* Work Permit*

***Please attach a copy of your Work Permit and/or Visa to your application form**

Full driving licence Yes No Access to own transport? Yes No

Do you have any endorsements? Yes* No

*If YES please provide details including dates:

Education



Secondary Education (continue on a separate sheet if necessary)

Name of School	Subjects	Level	Date From	Date To
			/	/
			/	/
			/	/

Further Education (continue on a separate sheet if necessary)

Name of University/College	Qualification	Level	Date From	Date to
			/	/
			/	/
			/	/

Details of other qualifications and training attended that would support your application

Career Details



Please provide details of your employment during the past 5 years (starting with the most recent)

Present/ Previous Employer

From **Month** **Year** **To** **Month** **Year** **Notice Period** _____

Type of Business

Job Title **Salary** £

Address
Post Code

Reason for leaving

Previous Employer

From **To**

Type of Business

Job Title **Salary** £

Address
Post Code

Reason for leaving

Previous Employer

From **To**

Type of Business

Job Title **Salary** £

Address
Post Code

Reason for leaving

Please continue on a separate sheet if necessary

References



Please provide below the details of two people who we can contact for references, **one of whom should be your current or most recent employer.**

REFEREE 1

Full Name

Address
Post Code

Relationship to you

Telephone **Fax**

Email

REFEREE 2

Full Name

Address
Post Code

Relationship to you

Telephone **Fax**

Email

If you are shortlisted, references may be sought before interview. If you **do not** wish us to contact your referees before your interview please tick this box

Criminal Records Bureau



Have you ever been convicted or cautioned for a criminal offence? YES NO
(If yes, please provide a separate sheet with details)

Have you ever been placed on the Protection of Vulnerable Adults register? YES NO
(If yes, please provide a separate sheet with details)

Are you aware of any police enquiries undertaken following allegations made against you, which may have a bearing on your suitability for this position? YES NO
(If yes, please provide a separate sheet with details)

You will be required as part of the application process to be checked by the Criminal Records Bureau. The provisions relating to the non-disclosure of criminal convictions do not apply. The position you are applying for is exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act.

Working Time Directive

WTD 1998 says that you the temporary Worker do not have to work on an Assignment with the Client in excess of the 48 hour Working Week unless you agree in writing that this limit should not apply.

YES I consent to opting out of Maximum hours NO I don't want to work more than 48 hours

If offered this position, do you intend to continue working in any other capacity? YES/NO
(If yes, please provide a separate sheet with details)

Disabilities

Do you consider yourself to have a disability? YES NO
If yes, please provide details on a separate sheet and where appropriate state:

- a) Any reasonable adjustments which you feel should be made to assist you in your application;
- b) Any reasonable adjustments which you feel should be made to the job environment itself which would enable you to carry out the role;
- c) What steps, if any, you are able to take to minimise any effect on your job.

Data Protection

The **Data Protection Act** requires that personal information is obtained and processed fairly and lawfully; is only disclosed in appropriate circumstances; is accurate, relevant and not held for longer than necessary; and is kept securely.

For the purposes of processing this application, the information you have provided on this form will be entered onto a computer but under the terms and conditions of the **Data Protection Act 1998** will be treated in a **secure and confidential manner**.

DECLARATION

I confirm that the information I have given on this form is correct and complete to the best of my knowledge. I understand that the giving of false information or misleading statements or deliberately withholding material information will disqualify me from employment or may result in disciplinary action, including dismissal or cancelling any agreements made. I undertake to notify the Company immediately of any changes to the above details.

Given the nature of the job for which I have applied, I understand that any offer of employment will be subject to information on my criminal record being disclosed to the Company by the Criminal Records Bureau/Disclosure and upon successful obtaining of satisfactory references from the referees named above.

Signed

Date

Personal Health Questionnaire



Title

Forename(s)

Surname

Do you or have you ever suffered from: (Please tick the sections applicable to you)

Serious Illness	<input type="checkbox"/>	Frequent Colds/Sore Throats	<input type="checkbox"/>
Serious Injury	<input type="checkbox"/>	Pneumonia / Bronchitis	<input type="checkbox"/>
Surgical Operations	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>
Allergies and Other Skin Sensitivities	<input type="checkbox"/>	Severe or Frequent Indigestion	<input type="checkbox"/>
Eye Problems	<input type="checkbox"/>	Recurring Bowel trouble	<input type="checkbox"/>
Colour Blindness	<input type="checkbox"/>	Kidney or Bladder Problems	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	Hernia / Rupture	<input type="checkbox"/>
Recurring Headaches	<input type="checkbox"/>	Backache, Slipped Disc etc	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	Hepatitis or Jaundice	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Physical Handicap	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Recurrent Chest Pain	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>
Cough / Shortness of Breath	<input type="checkbox"/>	Depression or other Nervous Illness	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Epilepsy/Fits or Fainting	<input type="checkbox"/>

Have you got any Disability Affecting (please tick as appropriate):	
Standing	<input type="checkbox"/>
Walking	<input type="checkbox"/>
Sitting	<input type="checkbox"/>
Lifting	<input type="checkbox"/>
Use of hands	<input type="checkbox"/>
Work at heights on Ladders/Staging	<input type="checkbox"/>
Ability to Drive a Motor Vehicle	<input type="checkbox"/>

Do you have or have you ever suffered from or been exposed to: (Please tick)

MRSA	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Typhoid Fever	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Paratyphoid F	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If you ticked any of the above, please provide details on a separate sheet and attach it with this application.

In the last 2 years have you been off work because of illness or injury?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If yes, how long were you absent?				
Are you at present having any treatment or medicine prescribed by a doctor?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you now made a full recovery from your illness or injury? (If no, a Doctor's Certificate is required stating that you are safe to return to work) (copy to be kept in Head Office)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Additional details:

Declaration

I certify that to the best of my knowledge and belief the above statements are complete and accurate. I understand that withholding or mis-stating of facts requested for the above may invalidate any contract of employment that may be offered to me.

Signature	Date
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Please return this form with your application form



Equal Opportunities Form

MBI Homecare Ltd fully supports the concept of equal opportunities at work. Thus our policy aims to certify that all applicants are given an equal opportunity of employment and progression within MBI Homecare regardless of their sex, race, colour, sexual orientation, disabilities, marital status, religion, or ethnic origin.

In order to implement this policy fully and fairly, we kindly ask all applicants to provide us with the information below. This will further help us to conduct regular reviews to ensure that all our applicants are selected and employed without prejudice.

Ethnic Origin (tick the one applicable to you)	
White	<input type="checkbox"/>
Black Caribbean	<input type="checkbox"/>
Black Other (please specify)	<input type="checkbox"/>
Indian	<input type="checkbox"/>
Bangladeshi	<input type="checkbox"/>
Chinese	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>

Gender	
Female	<input type="checkbox"/>
Male	<input type="checkbox"/>

Age	
18-20	<input type="checkbox"/>
21-29	<input type="checkbox"/>
30-49	<input type="checkbox"/>
50-64	<input type="checkbox"/>
65+	<input type="checkbox"/>

Signature	Date
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