SUPREME CARE SERVICES

APPLICATION FORM

(PLEASE COMPLETE IN BLOCK CAPITALS ONLY)

PERSONAL DETAILS		
Title	**Forename**	**Maiden Name**
Surname		
Address		
Telephone		**Mobile**
Email Address		**Date of Birth** (dd/mm/yyyy)
NI No.		**Nationality**
Speciality:		
Position applied for:		
NEXT OF KIN DETAILS		
Name		**Relationship**
Address		
Telephone	**Mobile**	**Work**
EDUCATION (please give details of your most recent education)		
Name and Address of School/College/University		
Name of course(s)		
Start Date(mm/yyyy)		**End Date**(mm/yyyy)
Qualifications achieved		

PROFESSIONAL REGISTRATION				
NMC Pin	**Date of expiry**			
Other Professional Bodies				
Organising Body			**Registered since** (mm/yyyy)	
EMPLOYMENT HISTORY (please detail all your employment of the last 10 years, starting with the most recent, giving reasons for any gaps)				
Name and Address of employer	**Position held, duties and responsibilities**	**From** (mm/yyyy)	**To** (mm/yyyy)	**Reason for leaving**

TRAINING (please detail any relevant training you have completed e.g. Manual Handling, Infection Control, Basic Life Support)

Training provider	Course(s) taken	From (mm/yyyy)	To (mm/yyyy)	Attainment

EXPERIENCE (please indicate below the specialties of which you have significant post NMC registration experience)

A&E	☐	HDU	☐	Paediatrics	☐
Anaesthetics	☐	ITU/ICU	☐	Research	☐
Burns and Plastics	☐	Learning Disabilities	☐	Recovery	☐
Cardio-Thoracic	☐	Mental Health	☐	Renal Nursing	☐
Critical Care Unit	☐	Midwifery	☐	Surgical	☐
Community Nursing	☐	Neurology	☐	Tropical Diseases	☐
Elderly Care	☐	Neonatal Unit	☐	Venepuncture	☐
ENT	☐	Occupational Health	☐	Wound care	☐
Gynae-Obstetrics	☐	Orthopaedics	☐		

Please detail any other speciality in which you are experienced

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REFERENCES (please detail two professional referees from your current or most recent employment)

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Name	**Name**
Position	**Position**
Organisation	**Organisation**
Address	**Address**
Contact Number	**Contact Number**
Email Address	**Email Address**

DECLARATION Part 1

HOME OFFICE CIRCULAR HOC 102/88

ALL APPLICANTS MUST ANSWER ALL QUESTIONS ON THIS FORM, FAILURE TO SO WILL INVALIDATE YOUR APPLICATION

In accordance with the above circular, you are required to provide the following information which will be passed on to the police authorities to check the existence and content of any criminal record. Because of the nature of the work for which you are required, jobs and assignments are exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974 (Exemptions) (Amendments) Order 1986. Applicants are, therefore, not entitled to withhold information about convictions, reprimands or final warnings which, for other purposes, are 'spent' under the provisions of the Act and in the event of employment, any failure to disclose such convictions. Please note that this information will only be provided to and checked with the police authorities after a recruitment interview has taken place.

Have you ever been convicted of a criminal offence, cautioned, sentenced, reprimanded or given a final warning by the police? Yes ☐ No ☐

If yes, please give details		
Full Name		
Current Address	**Previous Address (must cover previous 5 years)**	
At current address since	**Date of birth** (dd/mm/yyyy)	**Eye colour**
Maiden Name	**Place of birth**	**Height**
Any other identifying particulars		

I consent to the above information being checked with the police and I am aware that any 'spent' convictions will be disclosed

Signed	**Print Name**	**Date**

DECLARATION Part 2

DISCIPLINARY ACTION

Have you ever been subject to disciplinary action? Yes ☐ No ☐

If yes, please give details (use additional sheets if necessary)

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CODE OF CONDUCT

I have read and understood the terms and conditions of employment and code of conduct for Supreme Care Services employees. I agree to abide by the terms and conditions and uphold the code of conduct at all times

Signed	Print Name	Date

CONFIDENTIALITY AGREEMENT

I agree that during the time I am engaged by Supreme Care Services to work in any capacity:

1. I will not disclose to any person, any information obtained whilst attending an assignment
2. I will hold in trust and confidence for Supreme Care Services, all such information, and never use it other than for the benefit of Supreme Care Services

Signed	Print Name	Date

DECLARATION Part 3

If you provided false or misleading information to support your application it will disqualify you from being engaged as an agency worker by Supreme Care Services

I hereby declare that I have understood and complied with the requirements laid down in the application and I agree that the information given on this form may be used to obtain a CRB disclosure from the policy authorities

Signed	Print Name	Date

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EQUAL OPPORTUNITIES MONITORING FORM

Supreme Care Services Limited is committed to promoting Equal Opportunities. Our policy is to ensure that job applicants and employees receive equal treatment irrespective of their race, gender, religion, age or disablement. By completing all sections of this form you will help us to monitor the effectiveness of our Equal Opportunities policy. All information will be held in strict confidence.

Gender:

Male ☐ Female ☐ Other ☐ please detail

Age:

16-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55+ ☐

National/Racial Origin:

Asian	☐	Black	☐	White	☐	Mixed	☐
Pakistani	☐	African	☐	British	☐	please detail	
Bangladeshi	☐	Caribbean	☐	European	☐	Other	☐
Indian	☐	British	☐	Other	☐	please detail	
Other	☐	Other	☐	please detail		Prefer not to say	☐
please detail		please detail					

Disability

Do you consider yourself as having a disability that could affect your day-to- day work? Yes☐ No☐

If yes, please give details

Religion or Belief

No Religion	☐	Sikh	☐	Other	☐
Christian	☐	Muslim	☐	please detail	
Hindu	☐	Jewish	☐	Prefer not to say	☐

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HEALTH DECLARATION

Please complete this form and return it with the completed application forms. All the information given in this form will be treated as confidential and will not be divulged to a third party without your consent.

PERSONAL DETAILS	
Title	**Forename**
Surname	
Address	
Telephone	**Mobile**
GP DETAILS	
Name	**Telephone**
Address	

Please answer the following questions by ticking the appropriate below. If your answer is yes, please give further details

SECTION A

Have you ever had any of the following:

Eczema, dermatitis or other skin conditions	Yes☐ No☐
Ear Nose or Throat problems	Yes☐ No☐
Raised blood pressure	Yes☐ No☐
Heart or circulatory problems	Yes☐ No☐
Asthma, Hay Fever or ANY allergic conditions	Yes☐ No☐
Tuberculosis, Bronchitis, Pneumonia or Pleurisy	Yes☐ No☐
Episodes of severe chest pain or breathlessness	Yes☐ No☐
Severe headaches	Yes☐ No☐
Epilepsy, Fits, Blackouts or dizziness	Yes☐ No☐
Chronic indigestion, Abdominal pains, Gastric or duodenal ulcers	Yes☐ No☐
Liver disease or jaundice	Yes☐ No☐
Eye conditions, injuries or defects of sight	Yes☐ No☐
Persistent or Recurrent backache or injury	Yes☐ No☐
Rheumatism, arthritis or other joint problems	Yes☐ No☐
Kidney or bladder problems	Yes☐ No☐
Diabetes, problems with thyroid or other glands	Yes☐ No☐
Mental health problems such as depression, psychiatric treatment, nervous breakdowns	Yes☐ No☐
Neck injury or problems with the neck	Yes☐ No☐
Operations	Yes☐ No☐
Admission to hospitals	Yes☐ No☐
Serious illness	Yes☐ No☐
Serious accidents (at work or elsewhere) or visit to casualty	Yes☐ No☐

SECTION B

Are you currently taking or receiving any form of medication?	Yes☐ No☐
Do you smoke?	Yes☐ No☐
Do you drink alcohol?	Yes☐ No☐
Are you registered disabled or in receipt of a disability allowance	Yes☐ No☐
Do you normally wear glasses or contact lenses?	Yes☐ No☐
How many days have you lost through sickness in the last year?	Yes☐ No☐

Further details

If you have answered 'yes' to any of the above questions, please give further details here

DECLARATION

I know of no health reason that will affect my ability to undertake the duties required of me in the position for I am applying. All the answers given on this form are true and correct to the best of my knowledge.

Signed	Print Name	Date

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BANK OR BUILDING SOCITEY DETAILS

Please enter your Bank or Building society details below

Full Name		
BANK ACCOUNT DETAILS		
Name of Bank		
Branch		
Sort Code		
Account Number		
BUILDING SOCIETY DETAILS		
Name of Building Society		
Branch		
Sort Code		
Account Number		
Building Society Roll Number		
Signed	**Print Name**	**Date**

FOR OFFICE USE ONLY

Interviewed by_____ Interview date_____

Reference 1 ☐Sent_____ ☐Received_____

Reference 2 ☐Sent_____ ☐Received_____

ID Badge Issued ☐_____ ☐Uniform Issued_____

Notes _____

_____

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