GSTAR RESOURCES
people and performance professionals

Email: Recruitment@gstarresources.co.uk
Contacts: 02030929622

APPLICATION FORM

PRIVATE & CONFIDENTIAL

ATTACH PASSPORT PHOTOS

MR /MRS / MISS / MS (please delete as appropriate) .....

FIRST NAME: .....

MIDDLE NAME: .....

SURNAME: .....

DATE OF BIRTH: .....

NATIONAL INSURANCE NO:

ADDRESS: .....

POSTCODE: .....

HOME TELEPHONE: .....

MOBILE: .....

E-MAIL: .....

MARITAL STATUS: .....

NEXT OF KIN: .....

RELATIONSHIP: .....

ADDRESS: .....

POSTCODE: .....

PHONE NUMBER: .....

DO YOU HAVE PERMISSION TO WORK IN THE UK? YES / NO

DO YOU HAVE A VALID PASSPORT? YES / NO

YOU HAVE A VALID WORK PERMIT? YES / NO

MOBILITY:

DO YOU HAVE ACCESS TO A CAR YES / NO

WHICH CAN BE USED FOR WORK PURPOSES? YES / NO

DO YOU HOLD A FULL UK DRIVING LICENCE? YES / NO

QUALIFICATIONS / TRAINING

QUALIFICATIONS	SCHOOL/COLLEGE	GRADE/RESULT	DATES: FROM-TO

RELEVANT TRAINING/QUALIFICATIONS IN HEALTHCARE		CERTIFICATES DATE
Manual Handling	YES / NO	
Health and Safety	YES / NO	
Basic Food Hygiene	YES / NO	
First Aid	YES / NO	
NVQ Levels	YES / NO	
Others (please list)	YES / NO	

EMPLOYMENT HISTORY / WORK EXPERIENCE

Please record all employment in the past 5 years, including current employment by other agencies, and any other relevant experience gained within the health care field. Please start with the most recent. Please note that we shall obtain a reference from your LAST EMPLOYER

EMPLOYER NAME, Address & Telephone:	FROM - TO	Position held, Duties and Responsibilities	Reason for Leaving

REFERENCES

(1a) Must be your most recent employer (of at least 3 months duration) which must correspond with your employment history.

Name of Employer: .....

Address of employer: .....

.....

.....

Telephone Number: .....

E-mail: .....

Fax Number: .....

(1b) Another of your Employers in the last 3 years:

Name of Employer: .....

Address of employer: .....

.....

.....

Telephone Number: .....

E-mail: .....

Fax Number: .....

(2) Must be a fellow health care professional who does not live with you and is able to supply a character Reference of your personal and professional profile.

Name of Employer: .....

Address of employer: .....

.....

.....

Telephone Number: .....

E-mail: .....

Fax Number: .....

HEALTH DECLARATION

Carers / Support workers are required to complete this Health Declaration.
Any positive answers will not necessarily affect your application. Please list any medical conditions (past or present) which may affect your ability to do the job.

OCCUPATIONAL HEALTH ASSESSMENT	YES / NO	Details
Are you in good health?		
How much time have you lost from work due to illness in the last five years?		
Please provide details		
Have you ever been treated in hospital for serious illness or surgery? Please give dates		
Have you been treated in hospital during the last 12 months?		
Do you have any physical disabilities that could affect your ability to carry out your assignment?		
Have you ever left, been retired or denied a job on health grounds?		
Have you ever been denied a driving licence on health grounds?		
Are you a registered disabled person?		
Have you any disability related to your physical or mental health?		
Have you ever suffered from any mental illness, psychological or psychiatric problems?		
Do you get discomfort or pain in the chest or shortness of breath on exercise?		
Have you ever had any problems with your joints, including pain, swelling or stiffness?		
Do you have any difficulty in moving rapidly over short distances?		
Would you have difficulty looking over either shoulder?		
Do you need to wear glasses or contact lenses?		
Do you have any difficulty with your eyesight which is not corrected by glasses or contact lenses?		
Have you any problems working with Visual Display Units?		
Have you any problems working in confined spaces/using lifts?		
Do you have any difficulty hearing normal conversation?		
Are you taking any medication that makes you dizzy or drowsy?		
Do you have a medical condition affected by changing sleeping patterns or affecting day time sleep?		
Have you suffered from any alcohol or drug related illness or had an alcohol or drug problem?		
Are you having or awaiting any treatment at the moment?		
What is the date of your last chest x-ray?		
Are you receiving Medicines, Pills or Tablets from a doctor or on prescription?		
Have you ever suffered from any of the following?		
Heart Problems / Circulatory Illness/Hypertension		
High or Low Blood Pressure		
Diabetes		
Asthma / Hay fever		
Bronchitis/Pneumonia/Pleurisy		
Tuberculosis		
Epilepsy / Fainting Attacks / Blackouts /Fits / Sudden Collapse		
Headaches / Migraine		
Psychiatric Illness /Anxiety / Depression		
Dermatitis / Skin Sensitivity / Psoriasis /Eczema /Allergies		
Back Injury/Back Problems/Back Pains		
Recurrent Infections e.g. Sore Throats / Ear Infections / Eye Infections		
Hepatitis /Jaundice		

Have you ever been Vaccinated, Immunized or
Tested for / against any of the following?

	YES/NO	DETAILS
Tuberculosis incl BCG, Heaf, Mantoux or Tine		
Rubella (German Measles)		
Poliomyelitis		
Hepatitis B		
Hepatitis B Anitbodies Date and Result		
HIV		
Tetanus		
Typhoid		
Any Other		

DOCTOR INFORMATION

GP Name: .....

Address: .....

Postcode: .....

Phone: .....

WORK PREFERENCE

To assist us in finding suitable work for you, please place a tick next to all specialties of which you have significant recent experience and are confident to carry out such duties.
Please keep us informed from time to time of all developments in your career as the work we assign to you depends on accurate up to date information.

WORK PREFERENCE:
(Please Fill)

Full time: .....

Part time: .....

If part time, how many hours per week do you want to work: .....

Home care and pop-in visits / Hospitals / Nursing / Residential Homes / Morning / Day / Evening / Night Sleeper duty :

.....

CARE/SUPPORT ASSISTANT ABILITY SCHEDULE

Please indicate Yes / No in the areas you have had Previous Experience.

PERSONAL HYGIENE		CARE DUTIES	
Bath / Shower / Strip Wash	Yes / No	Pressure area care	Yes / No
Bed Bath	Yes / No	Simple dressing procedure	Yes / No
Use of bath aids	Yes / No	Assisting with medication	Yes / No
Shaving	Yes / No	Terminal care	Yes / No
Mouth care(inc. dentures	Yes / No		
Care of Hair	Yes / No	**PRACTICAL TASKS**	
Care of Feet (exc.toe nails)	Yes / No	Light house work	Yes / No
Care of finger nails	Yes / No	Washing personal laundry	Yes / No
Dressing/undressing	Yes / No	Shopping	Yes / No
		Bed making/Linen Change	Yes / No
TOILETING		Collecting benefits	Yes / No
Continence care	Yes / No		
Bedpans /Commodes etc.	Yes / No	**ADMIN. ABILITIES**	
Changing a Catheter Bag	Yes / No	Confidentiality	Yes / No
Empting catheter bag	Yes / No	Report writing	Yes / No
		Recording instructions from	
		GP/DISTRICT NURSE	Yes / No
MOBILITY		Observing/recording	Yes / No
Manoeuvring and handling Course	Yes / No	Changes in Condition	Yes / No
Use of hoists (man./elec)	Yes / No	Previous exp.	
Use of walking aids	Yes / No	Private house	Yes / No
		Nursing/residential Home	Yes / No

EQUAL OPPORTUNITIES MONITORING

Employees are therefore put forward for work / shift irrespective of race, ethnic origin , disability, age and gender. In order to monitor the effectiveness of our policy, we request all candidates to provide the following information.

FULL NAME: .....

Age Group

16 – 20 ☐ 21 – 35 ☐ 36 – 50 ☐ 51+ ☐

Registered disability ☐

Unregistered disability ☐

No disability ☐

Please tick appropriately which best describes your Ethnic Origin.

White European ☐

White Other ☐

Black African ☐

Black Caribbean ☐

Black Other ☐

Indian ☐

Pakistani ☐

Chinese ☐

Other ☐

How did you hear about the post?

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REHABILITATION OF OFFENDERS ACT 1974

You are advised that you are not entitled to withhold information about convictions, which are regarded as spent under the Act'. This is due to the nature of the work involved renders the post exempt from sec. 4(2) of the Act in accordance with the Rehabilitation of Offenders Act 974 (Exceptions) Order 1975.

You are therefore required to give details of all convictions and cautions including 'spent' convictions. Any information, which you may give, will be strictly confidential and will be considered only in relation to this or a similar position for which you may be considered with Champions Recruitment.

Have you ever been convicted of a criminal offence? YES ☐ NO ☐

If yes, please give details of all convictions and cautions, including spent convictions and cautions: (please use a separate sheet if necessary)

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You are required to complete the Criminal Records Bureau's (CRB) Disclosure form. All health professionals registered with TEQ Healthcare Services Ltd are subject to this disclosure process in the interests of all parties concerned.

D E C L A R A T I O N

I declare that:

All information given is true in every respect. I have read and understood the Terms and Conditions and I agree to comply with the current Health and safety at work Act (ii) I have never been charged with, or convicted of an offence under any legislation dealing with Residential care or any offence involving dishonesty or violence.
(iii) I have been issued with a staff handbook and informed of the importance of reading and understanding it.

SIGNATURE: .....DATE ..... /..... /.....

CRIMINAL RECORDS BUREAU – ENHANCED DISCLOSURE

FORENAMES: ..... SURNAME: .....

I understand that before I can commence work with Champions Recruitment, I will need to be in possession of a CRB Enhanced Disclosure.

SIGNATURE: .....DATE ..... /..... /.....

DOCUMENTS NEEDED FOR REGISTRATION

- **VALID WORK PERMIT**
  (Or if Student, College ID and Student Visa,)

- **BRITISH**
  PASSPORT (or other current Home Office Document authorizing you to work in UK)

- **NATIONAL INSURANCE (NI) CARD**
  (Or P45 or P60 or letter confirming you have applied for Ni

- **PROOF OF ADDRESS**
  E.g. Driving Licence, Utility Bill, or any formal letter with your name and address

- **2 CURRENT PASSPORT SIZE PHOTOGRAPHS**

- **CRIMINAL RECORDS BUREAU CERTIFICATE (CRB) / DBS**
  You apply with us.

- **TRAINING CERTIFICATES**
  E.g. Moving & Handling, Basic Aid etc.
  If you do not have the certificates we can provide training

BANK DETAILS

FULL NAME: .....

ACCOUNT NAME: .....

BANK NAME: .....

BANK ADDRESS: .....

ACCOUNT NUMBER: .....

SORT CODE: .....

SIGNATURE: ..... DATE: .....

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