

just  
SOCIAL CARE

Please attach  
2 passport  
photographs  
here

## APPLICATION FORM

### SECTION 1 - PERSONAL DETAILS

SURNAME: TITLE (Mr/Mrs/Miss/Ms/Dr):  
FIRST NAME (S): DATE OF BIRTH:  
MAIDEN NAME: MARITAL STATUS:  
ANY PREVIOUS NAME(S): MALE  FEMALE   
CURRENT ADDRESS:  
POSTCODE: COUNTRY:  
TEL HOME: WORK: MOBILE:  
EMAIL: FAX:  
PERMANENT ADDRESS (if different from above)  
COUNTRY:  
NATIONAL INSURANCE NUMBER (where applicable)  
GSCC NO:  
SPECIALITY/CLIENT GROUP:

### SECTION 2 - NATIONALITY, VISA & INSURANCE DETAILS

NATIONALITY: COUNTRY OF ORIGIN:  
PLEASE GIVE DETAILS OF YOUR VISA STATUS BY CHOOSING FROM THE FOLLOWING:  
EU PASSPORT  WORKING HOLIDAY VISA  STUDENT VISA  RIGHT OF ABODE  ANCESTRAL VISA   
PLEASE STATE VISA EXPIRY DATE: DO YOU REQUIRE A WORK PERMIT? YES  NO   
**Please enclose a copy of your passport & copies of any UK entry stamps or certificates**  
DO YOU CURRENTLY HAVE PERSONAL INDEMNITY INSURANCE? YES  NO   
COMPANY & POLICY NUMBER: EXPIRY DATE:  
DO YOU BELONG TO A PROFESSIONAL BODY/UNION:

### SECTION 3 - EDUCATION, QUALIFICATIONS & TRAINING

UNIVERSITY/COLLEGE	QUALIFICATION	COMMENCED	QUALIFIED

PLEASE GIVE DETAILS OF ANY FURTHER QUALIFICATIONS OR TRAINING. **Please give dates & places.**


Please ensure that you supply a copy of ALL your professional certificates or documents.

### SECTION 4 - EMPLOYMENT HISTORY

PLEASE GIVE DETAILS OF ALL EMPLOYMENT IN THE PAST 5 YEARS. **Start with the most recent and cover at least the last five years. All gaps in work history must be accounted for.** (use seperate sheet if necessary)

EMPLOYER'S DETAILS	FROM	TO	POSITION	DUTIES/EXPERIENCE GAINED

## SECTION 5 - MANUAL HANDLING TRAINING

DO YOU HOLD TRAINING CERTIFICATES IN ANY OF THE FOLLOWING? (Please tick and provide proof)

Moving & Manual Handling	<input type="checkbox"/>	Prevention and Infection Control	<input type="checkbox"/>
Health and Safety	<input type="checkbox"/>	Handling of Violence & Aggression	<input type="checkbox"/>
Basic Life Support	<input type="checkbox"/>	Mental Health Act	<input type="checkbox"/>

## SECTION 6 - PROFESSIONAL REFERENCES

PLEASE SUPPLY DETAILS OF AT LEAST TWO PROFESSIONAL REFERENCES. **One reference must be from your most recent employer and at least one reference must be from a department head or above.**

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
TEL NO: \_\_\_\_\_ FAX NO: \_\_\_\_\_  
EMAIL: \_\_\_\_\_

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
TEL NO: \_\_\_\_\_ FAX NO: \_\_\_\_\_  
EMAIL: \_\_\_\_\_

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
TEL NO: \_\_\_\_\_ FAX NO: \_\_\_\_\_  
EMAIL: \_\_\_\_\_

## SECTION 7 - WORK REQUIREMENTS

TEMPORARY  PERMANENT  BOTH  AVAILABLE TO START WORK FROM:

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

DO YOU HAVE REGULAR USE OF VEHICLE? YES  NO

NEAREST UNDERGROUND/RAILWAY STATION:

## SECTION 8 - HEALTH

**PLEASE PROVIDE US WITH THE FOLLOWING GENERAL HEALTH INFORMATION, IF YOU ANSWER YES TO ANY OF THE QUESTIONS IN THIS SECTION PLEASE PROVIDE DETAILS**

HAVE YOU ATTENDED YOUR GP IN THE LAST YEAR? YES  NO

IF YES, WHY?

ARE YOU CURRENTLY TAKING ANY PRESCRIBED MEDICATIONS? YES  NO

IF YES, WHAT MEDICATION AND WHY?

DO YOU HAVE ANY CONDITION WHICH MAY AFFECT YOUR ABILITIES TO PERFORM YOUR DUTIES? YES  NO

IF YES, WHAT?

DO YOU HAVE OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING MEDICAL CONDITIONS:

CONDITION	YES	NO	DETAILS/DATES
BLACKOUTS / EPILEPSY / DIZZY SPELLS			
HEART / CIRCULATORY PROBLEMS			
HYPERTENSION			
ASTHMA / BRONCHITIS / PLEURISY			
TUBERCULOSIS (TB)			
ECZEMA / PSORIASIS			
DIABETES			
MAJOR OPERATIONS / SERIOUS ILLNESS			
RHEUMATISM / ARTHRITIS			
CHICKENPOX			
ALLERGIES (INCLUDING LATEX)			
BACK, UPPER LIMB OR NECK INJURY			
NERVOUS/MENTAL ILLNESS OR EATING DISORDER			
BLOOD DISORDERS/ANAEMIA/HAEMOPHILIA			

HAVE YOU EVER BEEN SCREENED FOR VARICELLA/RUBELLA/TUBERCULOSIS/HEPATITIS B? YES  NO

(Please tick and provide proof)

## SECTION 9 - PROFESSIONAL CONDUCT

HAVE YOU EVER BEEN THE SUBJECT OF PROFESSIONAL MISCONDUCT PROCEEDINGS OR DISCIPLINARY PROCEEDINGS OR DISCIPLINARY ACTION FROM AN EMPLOYER, OR ARE SUCH PENDING OR THREATENED AGAINST YOU EITHER IN THE UK OR ABROAD?

YES  NO  IF YES PLEASE GIVE DETAILS:

## SECTION 10 - REHABILITATION OF OFFENDERS ACT

The Rehabilitation of Offenders ACT 1974 permits persons in certain circumstances to ignore offences committed in the past when asked to give details of previous convictions. These convictions are known as “spent convictions”. However the Exceptions Order of 1975 states that those employed in the medical/care fields are not allowed to withhold details of any offences for which they have been convicted, however long ago these convictions may have been saved.

DO YOU HAVE ANY CONVICTIONS OR CAUTIONS YES  NO

PLEASE DETAIL BELOW ALL CONVICTIONS AND CAUTIONS REGARDLESS OF THE SERIOUSNESS OF THE OFFENCE AND HOW LONG AGO THE CONVICTION OCCURED:

**This information may be shared confidentially and at an appropriate level with prospective employers to enable them to make a recruitment decision**

## SECTION 11 - CRIMINAL RECORDS BUREAU (CRB)

All recruitment agencies and NHS bodies are required by law to ask all applicants to apply for an Enhanced CRB Disclosure, as the job for which you are applying may involve access to children and vulnerable adults. It is therefore exempt from the Rehabilitation of Offenders Act 1974.

In order to secure work for you, we require a CRB check. If you already hold a Disclosure which is current, (within the last 3 years), please forward us the original document and sign the declaration below. Your Disclosure will be handled securely and returned to you via special delivery. Otherwise, we will need to apply for a CRB Disclosure. Full guidance notes and a CRB application form are enclosed. In order to ensure your application is processed quickly, it is important you complete the application in full and in accordance with the guidance notes.

DO YOU HAVE YOUR OWN COPY OF A CRB DISCLOSURE? YES  NO

IF YES - PLEASE ENCLOSE THE ORIGINAL

## SECTION 12 - EMERGENCY CONTACT DETAILS

PLEASE GIVE DETAILS OF THE PERSON YOU WOULD LIKE TO BE CONTACTED IN THE EVENT OF AN EMERGENCY

NAME:

RELATIONSHIP:

CONTACT DETAILS:

ADDRESS:

TELEPHONE:

EMAIL:

## SECTION 13 - BANK DETAILS

BANK NAME:

SORT CODE:

ACCOUNT NAME:

ACCOUNT NO:

ADDRESS:

## SECTION 16 - DECLARATION

I DECLARE THAT I HAVE **READ AND UNDERSTOOD JUST SOCIAL CARE TERMS & CONDITIONS**. I HAVE COMPLETED THIS FORM IN FULL AND ALL THE INFORMATION I HAVE PROVIDED IS CORRECT. I WILL NOTIFY JUST SOCIAL CARE OF ANY CHANGES TO MY PROFESSIONAL CONDUCT, FITNESS TO PRACTICE AND CRIMINAL CONVICTIONS STATUS. BY SIGNING THIS DECLARATION I AGREE TO EVERYTHING HEREIN.

SIGNED:

DATE:

NAME:

## SECTION 17 - CHECKLIST

PLEASE USE THE FOLLOWING CHECKLIST TO ENSURE THAT YOU HAVE ENCLOSED ALL DOCUMENTATION REQUIRED TO COMPLETE YOUR REGISTRATION PROCESS **(You are advised to send all original documents by special delivery)**

CV

ORIGINAL PASSPORT

NATIONAL INSURANCE CARD, INLAND REVENUE DOCUMENT OR PAYSリップ SHOWING NI NUMBER

2 X PASSPORT SIZED PHOTOS

DOCUMENTATION TO PROVE ANY NAME CHANGE (If applicable)

CERTIFICATES FOR ALL STATED QUALIFICATIONS & TRAINING

COMPLETED CRB DISCLOSURE APPLICATION FORM (If applicable)

2 X ORIGINAL, RECENT PROOFS OF ADDRESS

HEALTH INFORMATION DETAILS (If applicable)

ORIGINAL COPY OF YOUR CRB DISCLOSURE (If applicable)

PROOF OF PROFESSIONAL REGISTRATION

ORIGINAL PROOF OF IMMIGRATION STATUS

RECENT POLICE CHECK FROM YOUR OWN COUNTRY (If applicable)

**If you need any help or advice on completing this form and the documentation required to complete the registration process then please contact us and our staff will be only too happy to help. Please return your completed registration form to us using the contact details below.**

**Just Social Care  
Tel: 01375 641131**