Admiral Professionals Ltd
Helping and Caring with Love

CARE STAFF APPLICATION FORM

Please use BLACK INK and CAPITAL LETTERS throughout.

PERSONAL DETAILS

Title: .... Surname ....
Forename: .... Maiden Name ....
Middle Name: .... Marital Status: ....
Date of Birth: .... Male Female: ....
Age: .... National Insurance: ....
Address: ....
City / Town: .... Country: ....
Postcode: .... Home Telephone: ....
Mobile phone: .... Work Phone: ....
Pager No: .... Email Address: ....
Preferred Contact Method .... Are you willing to expect morning calls?
Yes ....No Are you willing to expect late Night calls? Yes: No____..

VARIOUS INFORMATION

Work status .... Passport Number: .... Exp date: / / ....
Nationality .... Birth certificate No: ....
Home Office Letter ref: .... Have Work Permit? Yes No
Work Permit Type .... Expiration Date: ....
Name of college/university (if student) ....
Have your own transport? .... Type of Transport? ....
Have you a driving license? .... If yes, any endorsement? ....
Religion .... Ethnic Origin ....
Children under 18 years? .... Ages ....
Do you smoke? Yes, No .... Registered Disabled? Yes No
Registration No: ....
Give details of hobbies/leisure activities ....
....
....
....
....
....

PROFESSIONAL EDUCATION AND TRANING.

Please list any Training / Course / healthcare qualification you have and when you gained them

Qualification: School / College University. Dates

Qualification	School / College University	Dates
……………………………	……………………………………	……………………
……………………………	……………………………………	……………………
……………………………	……………………………………	……………………
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……………………………	……………………………………	……………………

Please tick the specialities of which you have significant, post training experience. Please remember you have held accountable for any missing information.

SPCIALISM	LESS THAN 6 MONTHS	MORE THAN 6 MONTHS	1- 2 YEARS	2 YEARS +
Hospitals				
Learning Disability				
Adolescents				
Children				
Mental health				
Elderly				
Physical disability				
HIV				
Residential Homes				
Nursing homes				

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 ______________________________

Address ______________________________

____

____

Telephone: Main contact

Post Title: Grade

Full time or part-time Salary:

Main responsibilities:

Reason for leaving:

From / / To / /

Employer

Address

Telephone: Main contact

Post Title: Grade

Full time or part-time Salary:

Main responsibilities:

Reason for leaving:

From / / To / /

Employer

Address

Telephone: Main contact

Post Title: Grade

Full time or part-time Salary:

Main responsibilities:

Reason for leaving:

From / / **To** / /

Employer

Address

Telephone: Main contact

Post Title: Grade

Full time or part-time Salary:

Main responsibilities:

Reason for leaving:

HEALTH DECLARATION

Have you been vaccinated or tested against the following:	YES	NO	DETAILS (Plus dates if YES)
Covid-19			
Hepatitis B			

HIV			
Tetanus			
Poliomyelitis			
Typhoid			
Rubella (German Measles)			
Tuberculosis and BCG			
Hepatitis B Antibodies			
Mantoux, tine or Heaf			
Varicella			
Last X-ray			
Others (Specify)			
Do you or have you at any time suffered from any of the following	YES	NO	Details. (Required if YES)
Skin complaints- dermatitis, Psoriasis, Eczema			
Diabetes or glandular complaints			
Headaches or Migraine			
Hypertension/ heart problems/ similar illness			
Back pains / Back injury or problems			
Jaundice / Hepatitis			
Epilepsy or fainting attacks			
Pleurisy /Bronchitis / Pneumonia			
Asthma			
Infections - ear / sore throat			
Psychiatric illness - Mental disorder/ depression etc			
At present are you having any injections/medications	YES	NO	Details (if YES)
Are you under any treatment of any kind of condition?			
Have you had any major operations			
Physical Disabilities?			
How much time have you taken off work in the last 5 years due to illness?			
Please state any other information about your health which may affect your work			
If you do not have vaccination information, please provide details of where we can request them below.			

I certify the above information is correct and hereby give permission to the Agency to request a further report from my GP/ Occupational Health/ Hospital for clarification if required and for my health report.

GP /Occupational health/ Hospital ....
Address ....
Tel: .... Mobile ....
Email address: ....
Signed (Applicant) ....

WORK PREFERENCE

Please specify the kind of Care work you are interested in? (Tick all that apply)

NHS PRIVATE HOSPITAL NURSING HOME

RESIDENTAL HOME: OTHERS

(Please specify) SHORT TERM LONG TERM

Please indicate when you would like to work. Please tick all relevant boxes.

DAILY.

PART-TIME FULL-TIME BANK HOLIDAYS

EVENINGS (M-F) DAYS (M-F) NIGHTS (M-F)

EVENINGS (SAT-SUN) DAYS (SAT-SUN) NIGHTS (SAT-SUN)

AVALIBILITY

From when are you available to work come for an interview

Do you have any holiday booked? When:

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 offence? YES……………NO…………………..
If yes, please specify

Do you have any spent or unspent convictions YES NO
If yes please specify

Have you instigated an enhanced disclosure within the last six years? YES NO

I CONSENT TO ADMIRAL PROFESSIONALS STAFFING CHECKING THE DETAILS I HAVE PROVIDED AGAINST THE VARIOUS DATA SOURCES IN ORDER TO VERIFY MY INDENTITY AND PROCESS THIS APPLICATION. THESE DETAILS MAYBE USED TO ASSIST OTHER ORGANISATION SUCH AS CRB, AND IN IDENTITY PURPOSES.

SIGNATURE ____________________ DATED ____________________.

REFERENCES.

Please give the names and addresses of two of most recent employers with work addresses who is able to comment on your work ability and experience. Starting with your present to most recent employer if possible.

(A) ____________________

Name of Reference: ____________________ Company Name ____________________

Address: ____________________

____

____

Postcode ____________ city/ town; ____________ country ____________

Telephone no: ____________________ Fax no: ____________________

Email address: ____________________ Mobile phone: ____________________

Start date: / / End date: / / To date

(B) ____________________

Name of Reference: ____________________ Company Name ____________________

Address: ____________________

____

Postcode ____________ city/ town; ____________ country ____________

Telephone no: ____________________ Fax no: ____________________

Email address: ____________________ Mobile phone: ____________________

Start date: / / End date: / / To date

BUILDING SOCIETY /BANK DETAILS

Bank Name ____
Bank Address ____
____
____
Building Society Bank Roll ____
Holders Account Name ____
Sort Code ____________________ Account No ______________________________

I authorise **Admiral Professionals staffing Agency** to pay my weekly wages into the above Bank Account and I will notify **Admiral Professionals staffing Agency** if changes occur to my details.

Signed ____________________ Date ______________________________

NEXT OF KIN

Name of Emergency contact ____
Relationship to you: ____
Address: ____
____
____
Post code: ______________________________
Home Telephone: ____________________ Work No: ______________________________
Email Address: ____
Mobile No: ____________________ Pager: ______________________________

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 STATEMENT

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. The Agency is free to make any other enquiries they 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..

AGENCY INFORMATION. OFFICE USE

CHECKLIST		NOTES
Application		
Proof of Address	Utility bills, bank statements, others.	
Proof of identity	Passport, driving license others	
Eligibility to work	Visa, Work Permit, passport, birth cert	
CRB Application		
PAYE Form		
2 passport photographs		
Immunisation		
Signed contract		

AGENCY SIGN OFF

I Certify that I interviewed the above applicant in Accordance with **admiral professionals Staffing Agency** requirements and I am satisfied that this applicant is cleared for work

NAME OF CONSULTANT ______________________________

SIGNATURE OF CONSULTANT ______________________________

DATE ______________________________