



Post Applied for:

BYS Care and Training Services Ltd Job Application Form

Closing Date:

Interview Date:

Failure to complete ALL sections on this application form will result in your application being disregarded

THE INFORMATION YOU SUPPLY ON THIS FORM WILL BE TREATED IN CONFIDENCE.

Section 1 Personal details

Title: Mr Mrs Miss Ms

Last Name:

First Name:

Gender:

Male

Female

Address:

Postcode

D.O.B

Home Telephone N^o:

National Insurance N^o:

Letters						Numbers		Letter	

Daytime Telephone N^o:

Mobile Telephone N^o:

E-mail address:

Are you eligible to work in the UK?

Yes

No

Do you own a car?

Yes

No

Driver's Licence N.o.

Position: Full-time

Part-time

Next of Kin:

Contact Number:

Address:

If you are successful you will be required to provide relevant evidence of the above details prior to your appointment.

Section 2 Present Employment

Present Employment (If now unemployed give details of last employer)

Name of Employer:

Date of employment

From

To

Address:

Postcode:

Post title:

Date of Appointment:

Salary:

Department / Section:

Brief description of duties:

Continue on a separate sheet if necessary

Period of Notice: **Last day of service** (if no longer employed):

Reason for leaving (if no longer employed):

Section 3 Previous Employment

Previous Employment (most recent employer first). Please cover the last 10 years and state nature of business - if not public sector

Name of Employer:

Date of employment

From	To
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Address

Postcode

Position Held:

Summary of duties:

Reason for leaving:

Name of Employer:

Date of employment

From

To

Address

Postcode

Position Held:

Summary of duties:

Reason for leaving:

Name of Employer:

Date of employment

From

To

Address

Postcode

Position Held:

Summary of duties:

Reason for leaving:

Section 4 Education

Qualifications obtained from Schools, Colleges and Universities. Please list highest qualification first:

College or University			Course	Qualifications and grades obtained
From	To	Name of Col/University		
School			Subjects	Qualifications and grades obtained
From	To	Name of school		

Continue on a separate sheet if necessary

Section 5 Training and Development

Please give relevant details of any training or courses you have attended (e.g. First Aid, NVQ etc);

Practical Experience (FOR THOSE APPLYING FOR CARE / SUPPORT WORK ONLY)					
<i>To assist us in finding suitable work for you, please tick all the care tasks in which you are experienced:</i>					
Personal hygiene		Practical tasks		Toileting	
Bath/Shower/Strip wash	<input type="checkbox"/>	Bed making/ changing a bed	<input type="checkbox"/>	Applying a coveen	<input type="checkbox"/>
Bed bath	<input type="checkbox"/>	Collecting benefits	<input type="checkbox"/>	Attaching a night bag	<input type="checkbox"/>
Care of eyes	<input type="checkbox"/>	Cooking	<input type="checkbox"/>	Bed Pans / Commodes	<input type="checkbox"/>
Care of feet (exc. Toenails)	<input type="checkbox"/>	Light house work	<input type="checkbox"/>	Changing a catheter bag	<input type="checkbox"/>
Care of fingernails	<input type="checkbox"/>	Recording of blood pressure	<input type="checkbox"/>	Continence care	<input type="checkbox"/>
Care of hair	<input type="checkbox"/>	Recording of respiration	<input type="checkbox"/>	Emptying a caterer bag	<input type="checkbox"/>
Dressing / Undressing	<input type="checkbox"/>	Recording of respiration	<input type="checkbox"/>	Stoma care	<input type="checkbox"/>
Mouth Care (inc, dentures)	<input type="checkbox"/>	Shopping	<input type="checkbox"/>		<input type="checkbox"/>
Shaving	<input type="checkbox"/>	Washing personal laundry	<input type="checkbox"/>		<input type="checkbox"/>
Use of bath aids	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Administrative abilities		Mobility		Previous experience in :	
Confidentiality	<input type="checkbox"/>	Moving & Handling clients	<input type="checkbox"/>	Hospital	<input type="checkbox"/>
Observing/recording	<input type="checkbox"/>	Moving & handling course	<input type="checkbox"/>	Nursing/residential home	<input type="checkbox"/>
Changing in clients conditions	<input type="checkbox"/>	Use of hoists (main. /elec.)	<input type="checkbox"/>	Private house	<input type="checkbox"/>
Recording instructions from GP/Distance nurse	<input type="checkbox"/>	Use of walking aids	<input type="checkbox"/>		<input type="checkbox"/>
Care Duties		Nutrition			
Assisting with medication	<input type="checkbox"/>	Feeding	<input type="checkbox"/>		<input type="checkbox"/>
Pressure area care	<input type="checkbox"/>	Food Handling	<input type="checkbox"/>		<input type="checkbox"/>
Simple dressing procedures	<input type="checkbox"/>	Preparing meals	<input type="checkbox"/>		<input type="checkbox"/>
Terminal Care	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

Please explain briefly how you gained this experience:				

Cares experience Checklist For those APPLYING FOR CARE/ SUPPORT WORK ONLY

Please indicate your level of proficiency according to the scale below

I- No experience II- Previously performed but not proficient III- Competent to perform independently

PLEASE INDICATE WHAT AREAS OF CARE EXPERIENCE YOU HAVE DONE:						
Area		NHS / Private/ Local Authority	Month /Years	Level of Proficiency		
				I	II	III
Nursing Home	Frail elderly			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	EMI			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Nursing Home	Frail elderly			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	EMI			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Care	Clients own Home			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital (Specify area of work)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community (Specify area of work)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health (Specify area of work)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disabilities (Specify area of work)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Health / Industrial (Specify area of work)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of Practice		Data Achieved				
NVQ 1						
NVQ 2						
NVQ 3						
Please State						

Training Received	Date	Certified Supplied
Manual Handling		
Infection Control		
Fire Safety		
Fire Aid		
Essential Food Hygiene		
Lone Worker		
Management of aggressive / violent behavior		
Other, please specify:		

Section 6 Personal Statement

Abilities, skills, knowledge and experience.

Please use this section to explain in detail why you have applied for this position.

Continue on a separate sheet if necessary **Section 7 Rehabilitation of Offenders Act (1974)**

Do you have any convictions that are unspent under the rehabilitation of offender's act 1974?

Yes No

If yes, please give details / dates of offence(s) and sentence:

Section 8 Protecting Children and Vulnerable Adults

Due to the nature of our business, you are required to submit a Criminal Records Bureau check. Any enhanced disclosures made by the CRB will remain strictly confidential.

Do you agree for the CRB check to be made? (see enclosed CRB form)

Yes No

Do you agree for a POVA check to be made

Yes No

Section 9 Disability Discrimination Act

Do you suffer from a disability? Yes No

working hours o your performance? Yes No premises יור xir

If Yes we may be able to consider any reasonable steps so long as they are effective, practical and affordable.

Please state what adjustment may need to be made:

Are you mentally and physically able to carry out the duties required? Yes No If No please State reason why

If yes, please give details:

We will try to provide access, equipment or other practical support to ensure that people with disabilities can compete on equal terms with non-disabled people.

Do we need to make any specific arrangements in order for you to attend the interview? Yes No

If yes, please give details:

Section 10 - Declaration of Health Immunisations

BDG	Yes <input type="checkbox"/>	Date __/__/____	No <input type="checkbox"/>	Hepatitis B Date of injection: __/__/____
Skin Test for TB	Yes <input type="checkbox"/>	Date __/__/____	No <input type="checkbox"/>	Booster 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/>
Tetanus	Yes <input type="checkbox"/>	Date __/__/____	No <input type="checkbox"/>	Date of Blood Test __/__/____
Chickenpox/Vz. Abs.	Yes <input type="checkbox"/>	Date __/__/____	No <input type="checkbox"/>	Results: _____
Poliomyelitis	Yes <input type="checkbox"/>	Date __/__/____	No <input type="checkbox"/>	
Rubella _____ Other, Please specify _____	Yes <input type="checkbox"/>	Date -/-/ -	No <input type="checkbox"/>	IUL:

MEDICAL QUESTION

Are you at present taking any medication or receiving any treatment? Yes

If yes please give details:

GP Name:		GP Address:
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May we contact your GP regarding any health concerns? Yes

Section 10 Health

Successful applicants will be required to complete a detailed medical questionnaire and may be required to be appointed.

Number of days sickness absence in the last 2 years:

Please state number of occasions in the last 2 years:

HAVE YOU EVER HAD PROBLEMS WITH:			PLEASE GIVE DETAILS
	Yes	No	
Raised blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Heart of circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Chest complaints e.g. Asthma, Bronchitis, pleurisy, Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic indigestion	<input type="checkbox"/>	<input type="checkbox"/>	

	—	—	
Bowel complaints	<input type="checkbox"/>	<input type="checkbox"/>	
Persistent abdominal pains	<input type="checkbox"/>	<input type="checkbox"/>	
Liver disease or jaundice	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes, problems with thyroid or other glands	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney or bladder problem	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy, blackouts or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been made ill by your work	<input type="checkbox"/>	<input type="checkbox"/>	
Been refused a drivers license because of ill health	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been refused or dismissed from employment for Health reasons	<input type="checkbox"/>	<input type="checkbox"/>	
Persistence or recurrent backache or injury	<input type="checkbox"/>	<input type="checkbox"/>	
Neck injury / problems with neck	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema, Dermatitis or other skin disease	<input type="checkbox"/>	<input type="checkbox"/>	
Ear, nose o throat problems	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatism, Arthritis or other joint problems	<input type="checkbox"/>	<input type="checkbox"/>	
Vision problems or eye disease	<input type="checkbox"/>	<input type="checkbox"/>	
Heart, Lung, stomach, skin disease	<input type="checkbox"/>	<input type="checkbox"/>	
Need glasses to read	<input type="checkbox"/>	<input type="checkbox"/>	
Hay fever or allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Any other serious illness	<input type="checkbox"/>	<input type="checkbox"/>	
Are you registered Disabled?	<input type="checkbox"/>	<input type="checkbox"/>	

Section 11 References

Please give the names and addresses of your two most recent employers (if applicable). If you are unable to do this, please clearly outline who your references are.

Reference 1

Reference 2

Name:

Position (job title):

Work Relationship:

Organisation:

Address:

Postcode	

Telephone N°:

E-mail:

Name:

Position (job title):

Work Relationship:

Organisation:

Address:

Postcode	

Telephone N°:

E-mail:

Are you willing for this referee to be approached **Yes** **No**

referee to be approached **Yes** **No** prior to the interview? prior to the interview?

Section 12 Recruitment Monitoring Form

This sheet will be separated from your application form upon receipt and does not form part of the selection process. It will be retained by the Human Resources purely for monitoring purposes.

Application for the post of:

To help us ensure that our Equal Opportunities Policy is fully and fairly implemented (and for no other reason) please **COMPLETE THIS SECTION OF THE APPLICATION FORM.**

What is your Ethnic Group?

Choose ONE section from A to E, and then tick the appropriate box to indicate your cultural background.

<p>A. White</p> <p>White UK <input type="checkbox"/></p> <p>Irish <input type="checkbox"/></p> <p>White non-UK (please give details): <input type="checkbox"/></p> <p>Any other White background <input type="checkbox"/></p> <p><input style="width: 300px; height: 30px;" type="text"/></p>	<p>D. Black or Black British</p> <p>Black Caribbean <input type="checkbox"/></p> <p>Black African <input type="checkbox"/></p> <p>Any other Black background <input type="checkbox"/></p> <p><input style="width: 300px; height: 30px;" type="text"/></p>	<p>B. Mixed</p> <p>White & Black Caribbean <input type="checkbox"/></p> <p>White & Black African <input type="checkbox"/></p> <p>White & Asian (please give details): <input type="checkbox"/></p> <p>Any other Mixed background <input type="checkbox"/></p> <p><input style="width: 300px; height: 30px;" type="text"/></p>	<p>E. Chinese or other</p> <p>Chinese <input type="checkbox"/></p> <p>Vietnamese <input type="checkbox"/></p> <p>Any other ethnic background <input type="checkbox"/></p> <p><input style="width: 300px; height: 30px;" type="text"/></p>
<p>ethnic group</p> <p>not wish to provide this information <input type="checkbox"/></p>	<p>(please give details):</p> <p>C. Asian or Asian British</p>	<p>(please give details):</p> <p>F.I do</p>	

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background
(please give details):

Section 12 Recruitment Monitoring Form continued

Gender

- Male Female

Disability

Disability is defined as “physical or mental impairment, which has a substantial and long term adverse effect on a person’s ability to carry out normal day to day activities”.

- Do you consider yourself disabled? Yes No

If yes, please give details:

Age Group

- 16-25 26-35 36-45 46-55 56-65 66-70
- Over 70
-

Media

Please state where you saw this post advertised

For Office Use Only:

Start Date:		

1. Declaration

Statement to be Signed by the Applicant

Please complete the following declaration and sign it in the appropriate place below. If this declaration is not completed and signed, your application will not be considered.

I agree that Pringle’s Care Services can create and maintain computer and paper records of my personal data and that this will be processed and stored in accordance with the Data Protection Act 1998.

I confirm that all the information given by me on this form is correct and accurate and I understand that if any of the information I have provided is later found to be false or misleading, any offer of employment may be withdrawn or employment terminated.

Signed: Date:

Candidates selected for interview will normally be notified within four weeks of the closing date. If you return this form by email, you will be asked to sign your application at interview.

2.

Submitting your application

By Hand or Post:

BYS Care and Training Services LTD

108 Osram House

Eastlane Business Park

Wemley

HA9 7NG

By E-Mail:

admin@byst.co.uk

Telephone: 02033027972