Perfect Call Care Application Form

PLEASE COMPLETE BLOCK CAPITALS STATING YOUR FULL NAME AS IT APPEARS ON YOUR PROFESSIONAL REGISTRATION AND PASSPORT

Title:	**First Name**:	**Surname**:
Date Of Birth:	**Nationality**:	**National Insurance Number**:

Right to Work Have you got the legal right to work within the United Kingdom? **Yes/ No**. Passport (Please tick) ○ **British Passport** ○ **Travelers Document** ○ **European Economic National Area** ○ **Foreign National**	UK Entry Clearance Visa and Residence Permit Please tick the description that best describe your visa. ○ **Indefinite Leave to Remain** ○ **Refugee** ○ **Spousal Visa** ○ **Student Visa** ○ **Healthcare Services leave to remain- No remarks** ○ **Healthcare Services leave to remain- No remarks**

Position Applied For	
How many years of previous experience do you have on this position?	Do you have valid mandatory trainings?
Do you have a DBS registered on online update service?	If yes, please provide update service reference number below.

Current Address……

……Post Code……

Telephone…… Mobile……

Email Address _____

Next of Kin Details	Title:	First Name:	Surname	

Current Address……

……Post Code……

Telephone…… Mobile……

Email Address _____

Personal Statement *(In your words please tell us why you are a suitable candidate for this role)*.

Educational Qualification

Dates		**Name of School/College/**	Course/ Subjects studied	Grade
From	To			

Professional Qualification

Dates		**Name of /College/Universiity**	Course/ Subjects studied	Grade
From	To			

Work History *(please provide us with a detailed employment history for up to five years with all gaps explained).*

From	To			

Professional Reference: *Please provide us with at least three names, addresses, telephone numbers of the line managers we can contact for references. If you have had less than three previous employers for the last five years you can ask friends or relatives to provide us personal references.*					
Name		Surname		Position	
Address					
Post Code		Contact Number			
Email					
Name		Surname		Position	
Address					
Post Code		Contact Number		Position	
Email					

Name		Surname		Position	
Address					
Post Code		Contact Number			
Email					
Name		Surname		Position	
Address					
Post Code		Contact Number		Position	
Email					

Can we contact your referees before the interview: **Yes/No**	
Have you got a valid driving License ? **Yes/No**	Have you got access to a car? **Yes/No**

Asylum and Immigration act 1996

You are required to produce documents specified by the act to prove your eligibility to work. The terms of your employment will solely be subject to your continued eligibility to work in the UK. Perfect Call Care ltd will carry out checks with the Home Office for any Right to work documents provided by applicants during the recruitment process. Please note that all applicants must give consent for Perfect Call Care limited to carry out checks with the Home Office Agency. Failure to give consent may result to termination of the recruitment.

Do you give Perfect Call Care ltd permission to verify your documents with the Home Office?

Yes ☐ No ☐

Sign:		Date:	

Health Screening

Perfect Call Care will ask you to fill in a re-employment health screening questionnaire which will be assessed by Occupational Health. We may need to contact your local GP in order to identify if you are fit for the possession applied.

Criminal Records

Perfect Call Care Limited's jobs may involve working with frail or vulnerable people;
Because of the nature of work for which you are applying, this post is exempt from the provisions of Section 4.2 of the Rehabilitation of Offenders Act 1974 (Exemption order 1975). You are required to declare prosecutions or convictions, including those considered 'spent' under this Act.

Have you been convicted of a criminal offence, been bound over or cautioned or are you currently the subject of any police investigations, which might lead to a conviction, an order binding you over or a caution in the UK or any other country?

Yes ☐ No ☐ *Please tick appropriate*

Note

If Yes, please provide outline on a separate sheet the criminal offence, order binding you over, a caution, including approximate date, the offence and the authority and country which dealt the offence.

Declaration by Applicant

I confirm that the information in this application is true and accurate to the best of my knowledge and belief, I understand that any false information may result in the rejection of my application or, in the event of employment, dismissal or disciplinary action by **Perfect Call Care Ltd.**

Signed Date

Perfect Call Care will use this section to process all payments. Please make sure that all information is filled in accurately to the best of your ability.	
First Name	
Surname	
DOB	
National Insurance No	
Address	
Town	
Post Code	
Email Address	

Bank Name	
Name of Account Holder	
Account Number	
Sort Code	

Positioned Applied For	
Start Date	

48 Hour Waiver

The Working Time Regulations Act 1998 (the regulations) require the company to limit your average weekly working time to 48 hours unless you agree with the company that the limit shall not apply to you.

The company wishes to have an agreement with you. It proposes an agreement (which shall apply until terminated by notice) on basis that:

1) The 48-hour limit on average weekly working time will not apply to you.
2) You may terminate the agreement (so that the 48-hour time limit would not apply to you) by giving the Branch Manager one-week written notice. For avoidance of doubt, any notice bringing this agreement to and shall not be construed as termination by the employee of his/her employment with Perfect Call Care Ltd.
3) Under the regulations, the company must keep records relating to your working time. This is the case whether or not you reach an agreement with the company about waiving working time limits.

Please sign and date below if you accept to work more than 48 Hours at Perfect Call Care.

Sign	Date

The contents of this form will remain confidential and will not be disclosed to anyone without your written consent.	
1. Personal Details	
Surname:	**Forename(s):**
Any other surnames you have had:	**Male/Female:**
Title: Mr / Mrs / Miss / Ms / Doctor / Professor	**Date of Birth:**
Address:	
Post Code:	
Contact Details:	
Home:	**Mobile:**
Work:	**Email:**
2. Position applied for - Title of the position you have applied for	
This job may involve - Please tick all that apply	
Handling Service Users ☐ **Working with human blood, tissues, fluids** ☐ **Working Night Shifts** ☐	
Handling heavy goods ☐ **Using mobility equipment, hoists** ☐ **Driving** ☐	
Food Handling ☐ **Regular VDU usage** ☐	

For night shift workers: How long have you been working nights? What type of work?	**For night shift workers:** Have you suffered any health problems that are directly related to working night shifts? Please state:

3. Work Related History	**Yes**	**No**	**Please give details:**
Have you been absent from work or full-time study due to ill health during the last 12 months?			
Have you ever left or been denied a job on health grounds?			
Have you ever been denied a driving license on health grounds?			
Have you ever suffered from any work-related health conditions?			
Have you ever had an accidental sharps injury or exposure to blood/bodily fluids with broken skin or mucous membranes? If YES, please state opposite: • Date of the incident • Status of source if known • Details of treatment given at time of injury • Details of follow up blood test results/surveillance •			
4. Health History:			

Do you have or have you had in the past:	YES	NO	Please give details:
Conditions of the lungs? Asthma/bronchitis/pleurisy/tuberculosis/other chest complaints/coughing up blood/shortness of breath?			
Conditions of the heart? High blood pressure/heart attacks/angina?			
Nervous system disorder? Blackouts/epilepsy/muscular weakness/paralysis?			
Migraine or persistent headaches?			
Conditions of the digestive system? Irritable bowel syndrome/liver complaints/jaundice/colitis/gastric/duodenal ulcer?			
Conditions of the bones, joints and limbs? Arthritis/rheumatism/back problems/neck and shoulder problems/sciatica/upper limb disorder/tennis elbow/any other conditions?			
Allergies? Including allergies to drugs, animals and pollens			
Skin conditions? Eczema/dermatitis/psoriasis/recent infection/skin cancer?			
Gland trouble? Diabetes/thyroid – overactive/underactive?			
Eye conditions? Restricted vision/glaucoma/iritis/any other conditions			
Ear conditions? Restricted hearing/tinnitus/ear infections?			
Alcohol or drug problems? Problems related to alcohol or drug usage or dependency?			

Mental illness and/or stress related problems? Nervous breakdown/mental fatigue/anxiety/depression/panic attacks/significant sleep disturbance/stress related problems/eating disorders/self harm/any other conditions?			
Have you consulted a specialist or need any operations other than already stated?			
Have you spent any time in hospital other than already stated?			
Have you consulted your GP in the last 12 months?			
Are you receiving medical treatment at the present time?			
Do you take any regular medication?			
Are you aware of having any disability that is covered by the Disability Discrimination Act?			
Have you any disabilities affecting sight, hearing, standing, sitting, walking, lifting, driving, stair climbing, use of the hands or ability to carry out any work indicated in section 2?			
Have you been in contact with MRSA? If Yes – did you contact Occupational Health? Please detail the treatment you received and state whether you have been cleared. You are required to inform Perfect Call Recruitment Limited immediately should you come into contact with MRSA			
Have you any other health issues that have not been			

mentioned above or about which you would like to provide further details?			

5. Vaccination History	
To reduce the need for further blood tests, please provide a laboratory report or certificates signed and dated for your GP/ Vaccinated Centre or Occupational Health Department as evidence of any of the immunisations you have had as listed below:	
Immunisation and Blood Tests	**Dates and Results (attach evidence)**
Hepatitis B primary course	
Hepatitis B booster (s)	
Hepatitis B antibody blood test	
Varicella (proof of immunity)	
Diphtheria (proof of 10 yearly update/booster)	
Poliomyelitis (proof of 10 yearly update/booster)	
Tetanus (proof of 10 yearly update/booster)	
Rubella (proof of immunity)	
Measles (proof of immunity)	
Mumps (proof of immunity)	
TB skin test e.g. Heaf test	
BCG (protection against TB)	

HIV (negative result for exposure prone procedure)	
Hepatitis C (negative result for exposure prone procedures)	
Hepatitis B Surface Antigen (for exposure prone procedures)	

Clinical Staff - health care workers who perform exposure prone procedures must inform Occupational Health if they suspect or

know they are HIV positive.

DECLARATION FROM WORKER

I declare that the information give within this declaration of health is true and complete to the best of my knowledge. I understand and accept that I may be required to attend for an Occupational Health Assessment.

I understand and accept that further medical information may be requested from my doctor if considered necessary.

I understand that making false statements or failure to declare health problems could lead to removal from the Agency's register.

I agree to update this declaration of health on an annual basis.

PRINT NAME:	**SIGNATURE:**	**DATE:**

GENERAL PRACTITIONER DETAILS

GP Name:
Address:
Post Code: