



LENPAT LIMITED

Passport Photos

X 2

APPLICATION FORM PRIVATE & CONFIDENTIAL

TITLE:	
FIRST NAME:	
MIDDLE NAME:	
SURNAME:	
NATIONAL INS. NO.	
DATE OF BIRTH:	
ADDRESS	
POSTCODE:	
HOME TEL:	
MOBILE:	
E-MAIL:	
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	
Medication competency	YES/NO	
Safeguarding	YES/NO	
QCF levels	YES/NO	
Others (please list)	YES/NO	

EMPLOYMENT HISTORY / WORK EXPERIENCE

Please provide full employment after school with explanation for all the gaps, 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 & Tel no.	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) Character reference from an individual that is known to the employee but not living with him/her.

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	Ye s	No	Details
<i>Are you in good health?</i>			
<i>Have you been treated in hospital during the last 12 months?</i>			
<i>Do you have any physical disabilities that could affect your ability to carry out your duties?</i>			

<i>Do you have any disability</i>			
<i>Have you any mental health problem?</i>			
<i>Do you get discomfort or pain in the chest or shortness of breath</i>			
<i>Have you ever had any problems with your joints, including pain, swelling or stiffness?</i>			
<i>Do you have any difficulty in moving?</i>			

<i>Are you taking any medication that makes you dizzy or drowsy?</i>			
<i>Do you have a medical condition affected you capacity</i>			
<i>Are you having or awaiting any treatment at the moment?</i>			

<i>Are you receiving Medicines, Pills or Tablets from a doctor or on prescription?</i>			
<i>High or Low Blood Pressure</i>			
<i>Diabetes</i>			
<i>Tuberculosis</i>			

<i>Epilepsy/Fainting Attacks/Blackouts/Fits/Sudden Collapse</i>			
<i>Back Injury/Back Problems</i>			
<i>Hepatitis/Jaundice</i>			
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 Antibodies Date and Result			
HIV			
Tetanus			
Typhoid			
Covid-19			
Any Other			

Signature.....

Date.....

WORK PREFERENCE.

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 tick)

<i>Full time / Part time</i> <i>If part time, how many hours per week do you want to work...</i> <i>Home care and pop-in visits</i> <i>Hospitals</i> <i>Nursing/Residential Homes</i> <i>Morning / Day / Evening / Night Sleeper duty</i>	
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Live-In Care

<i>Please state if you are able to work as a 24-hour Residential (live-in) Carer.</i>	YES / NO
<i>If YES, would you like: Long..... or short assignments?</i>	
<i>Would you accept a live-in assignment some distance from your home?</i>	YES / NO
<i>If NO, please specify preferred areas:</i>	

Care/Support Assistant ability schedule

Please indicate yes / No in the areas you have had previous experience.

Personal hygiene		Care duties	
<i>bath/shower/strip wash</i>	Yes/No	<i>Pressure area care</i>	Yes/No
<i>bed bath</i>	Yes/No	<i>Simple dressing procedure</i>	Yes/No
<i>Use of bath aids</i>	Yes/No	<i>Assisting with medication</i>	Yes/No
<i>Shaving</i>	Yes/No	<i>Terminal care</i>	Yes/No
<i>Mouth care</i>	Yes/No		
<i>Care of hair</i>	Yes/No	Practical tasks	
<i>Care of finger nails</i>	Yes/No	<i>Washing personal laundry</i>	Yes/No
<i>Dressing/undressing</i>	Yes/No	<i>Shopping</i>	Yes/No
		<i>Bed making/changing bed linen</i>	Yes/No
Toileting		<i>Collecting benefits</i>	Yes/No
<i>Continence care</i>	Yes/No		Yes/No
<i>Bedpans/commodes etc.</i>	Yes/No	Admin. Abilities	
<i>Changing a catheter bag</i>	Yes/No	<i>Confidentiality</i>	Yes/No
<i>Emptying catheter bag</i>	Yes/No	<i>Report writing</i>	Yes/No
		<i>Recording instructions from GP/DISTRICT NURSE</i>	Yes/No
Mobility		<i>Observing/recording</i>	Yes/No
<i>Manual and handling course</i>	Yes/No	<i>Changes in clients condition</i>	Yes/No
<i>Use of hoists(man./electric)</i>	Yes/No	Previous exp.	
<i>Use of walking aids</i>	Yes/No	<i>Private house</i>	Yes/No
		<i>Nursing/residential home</i>	Yes/No

EQUAL OPPORTUNITIES MONITORING

Lenpat Limited Domiciliary Care Service is an equal opportunity employer. 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

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 Lenpat Limited?

Signature.....

Date.....

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 1974 (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 Lenpat Limited Domiciliary Care Service.*

*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 Disclosure and Barring Service (DBS) Disclosure form. All health professionals registered with Lenpat Limited Domiciliary Care Service are subject to this disclosure process in the interests of all parties concerned.

DECLARATION

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.....

Disclosure and Barring Service – ENHANCED DISCLOSURE	
Names.....	Surname.....
I understand that before I can commence work with Lenpat Limited Domiciliary Care Service, I will need to be in possession of a DBS Enhanced Disclosure.	
Signature.....	Date /..... /.....

DOCUMENTS NEEDED FOR REGISTRATION

- **VALID WORK PERMIT**
(Or if Student, College ID and Student Visa,)
- **Do you require a work permit? Yes /No**
- **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**

• **DISCLOSURE AND BARRING SERVICE**

(DBS) OR 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

Name

Account Name

Bank Name

Bank Address

Account Number

Sort Code

I confirm that the information given in this form is true, complete and accurate.

Signature.....

Date.....