



Caring Arms Together

Please add your picture in the box ↓

POSITION APPLIED FOR		DATE		<div style="border: 1px solid black; width: 100%; height: 100%;"></div>
FULL NAME				
DATE OF BIRTH				
LANGUAGES YOU CAN SPEAK?				

CONTACT DETAILS

HOME ADDRESS					
CITY		POST CODE			
DO YOU UK /EEA DRIVING LICENCE?	<input type="checkbox"/> YES <input type="checkbox"/> NO		DO YOU HAVE A CAR?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
MOBILE NO:		HOME TELEPHONE			
EMAIL ADDRESS					

EMERGENCY CONTACT DETAILS

NEXT OF KIN NAME		RELATION WITH YOU?	
NEXT OF KIN TELEPHONE NUMBER		NEXT OF KIN MOBILE NUMBER	

IF YOU ANSWER YES TO ANY QUESTION BELOW PLEASE EXPLAIN ON THE LAST PAGES IN EXTRA COMMENTS

HAVE YOU BEEN DISMISSED FROM ANY EMPLOYMENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU EVER BEEN OR CURRENTLY SUBJECT TO ANY INVESTIGATION OR DISCIPLINARY ACTION?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU EVER BEEN CONVICTED, SANCTIONED, OR HAVE AN OUTSTANDING WARRANT OR CAUTION	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU EVER LEFT A JOB WITHOUT NOTIFYING EMPLOYEER	<input type="checkbox"/> YES <input type="checkbox"/> NO

HAVE YOU BEEN VACCINATED FOR COVID 19 YES NO
 1st JAB DATE TAKEN 2nd JAB DATE TAKEN

PLEASE PROVIDE EVIDENCE OF VACCINATION TAKEN

HAVE YOU EVER WORKED IN THE UK BEFORE

IF NO PLEASE GO TO THE NEXT PAGE

WORK EXPERIENCE FOR LAST 15 YEARS

If you have worked before applying this job, you must write the employer's details as referee on next page. We will not accept any personal reference in case you have a work history. If you never worked before please write what you have been doing last 15 years.

PLEASE NOTE THAT WHOEVER DETAILS YOU PROVIDE BELOW WILL ALSO BE REQUIRED AS REFERENCES FOR YOUR APPLICATION AND WILL BE APPROCHED BY CARING HANDS

IF THESE RECORDS DO NOT MATCH YOUR APPLICATION WILL NOT BE PROCESSED

(most recent) COMPANY NAME		YOUR JOB TITLE	
ADDRESS		START DATE END DATE	
MAIN DUTIES			
REASON FOR LEAVING THIS JOB			
ANY GAP BETWEEN THIS AND PREVIOUS JOB			
REASON FOR GAP			
(2nd recent) COMPANY NAME		YOUR JOB TITLE	
ADDRESS		START DATE END DATE	
MAIN DUTIES			
REASON FOR LEAVING THIS JOB			
ANY GAP BETWEEN THIS AND PREVIOUS JOB			
REASON FOR GAP			
(3rd recent) COMPANY NAME		YOUR JOB TITLE	
ADDRESS		START DATE END DATE	
MAIN DUTIES			
REASON FOR LEAVING THIS JOB			
ANY GAP BETWEEN THIS AND PREVIOUS JOB			
REASON FOR GAP			

We need to know your last 15 years history, what you have been doing for last 15 years
PLEASE WRITE ALL YOUR TRAINING, EDUCATION AND QUALIFICATION HISTORY BELOW
PLEASE NOTE THAT YOU WILL NEED TO PROVIDE ALL EVIDANCE OF YOUR TRAINING AND
QUALIFICATIONS TO PROCESS YOUR APPLICATION

2006-2010

2011 – 2015

2016 - 2021

REFERENCES

Professional Reference: (if you have worked before, your reference should be from your most recent employer. Manager / HR

Personal Reference: Your reference should be from someone who knows you for 1 year or more, Referee should not be your relative or best friend, your referee should be a professional person

Institutional Reference: It could be from your Institution (college, University, Training Centre, supervision, assessor, trainer or a teacher).

Years Known : If the personal referee does not know you for more than 1 year, you may have to provide 4 references instead

Please Note we will be sending Reference Forms to all your below mentioned referees

REFERENCE NO 1 :

Please tick what reference is this	EMPLOYER	PERSONAL	INSTITUTIONAL
REFeree TITLE & FULL NAME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REFeree JOB TITLE	COMPANY NAME		
FULL WORK ADDRESS	REFeree CONTACT NUMBER		
EMAIL ADDRESS			
IN WHAT CAPACITY / RELATIONSHIP HAVE YOU KNOWN THE REFEREE			
HOW LONG HAVE YOU KNOWN ABOVE MENTIONED PERSON?			

REFERENCE NO 2

Please tick what reference is this	EMPLOYER	PERSONAL	INSTITUTIONAL
REFeree TITLE & FULL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REFeree JOB TITLE	COMPANY NAME		
FULL WORK ADDRESS	REFeree CONTACT NUMBER		
EMAIL ADDRESS			
IN WHAT CAPACITY / RELATIONSHIP HAVE YOU KNOWN THE REFEREE			
HOW LONG HAVE YOU KNOWN ABOVE MENTIONED PERSON?			

PLEASE ASK FOR ADDITIONAL PAGES IF REQUIRED FOR MORE REFERENCES TO INPUT

QUALIFICATIONS, SKILLS, EXPERIENCE AND COMPETENCY CHECK

QUALIFICATION IN HEALTH AND SOCIAL CARE (QCF/ NVQ LEVEL 1, 2, 3,4 OR 5) Please write only the highest qualification obtained	Year of completion
<input type="text"/>	<input type="text"/>

Have you completed Skill for Care “Care Certificate” before? Yes No
(If yes, please provide company name below also provide us the care certificate document.)

<input type="text"/>	If Yes, Year of completion?	<input type="checkbox"/> YES
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Have you obtained any other day trainings in Health and Social Care? NO
If yes please provide the certificates.

YOUR EXPERIENCE AND SKILLS IN HEALTH AND SOCIAL CARE / PROVIDING PERSONAL CARE

Please write the details of your highest education / qualification

Qualification /Education	<input type="text"/>		
Place of completion	<input type="text"/>	Year of completion	<input type="text"/>
Provide qualification / education certificate	<input type="text"/>	<input type="text"/>	<input type="text"/>

Can you read and write English?	<input type="text"/>
Can you speak English?	<input type="checkbox"/> Basic <input type="checkbox"/> Fluently <input type="checkbox"/> First language <input type="checkbox"/> cannot speak at all

Personal Declaration

I hereby confirm that the information provided on my application is correct and true to the best of my knowledge and that I have not withheld any information that should be taken into account when offering me work. I understand that providing false/inaccurate information may result in the termination of employment.

If you are not selected, the application and documents will be destroyed safely.

NAME	<input type="text"/>	SIGNATURE Type name if sending by email	<input type="text"/>
DATE	<input type="text"/>	For office use (received by) HR Signature If the person has been short listed, give the 2nd part of application.	<input type="text"/>

APPLICATION PART 2

EQUAL OPPORTUNITY FORM

Only successful applicants will be required to complete

Applicant Name:	<input type="text"/>		
GENDER	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	PREFER NOT TO SAY <input type="checkbox"/>
MARITAL STATUS	MARRIED <input type="checkbox"/>	SINGLE <input type="checkbox"/>	PREFER NOT TO SAY <input type="checkbox"/>
SEXUAL ORIENTATION	BISEXUAL <input type="checkbox"/>	GAY <input type="checkbox"/>	HETEROSEXUAL <input type="checkbox"/>
	LESBIAN <input type="checkbox"/>	OTHER <input type="checkbox"/>	PREFER NOT TO SAY <input type="checkbox"/>
	IF "OTHER", PLEASE SPECIFY <input type="text"/>		
RELIGION	BUDDHIST <input type="checkbox"/>	CHRISTIAN <input type="checkbox"/>	CHURCH OF SCOTLAND <input type="checkbox"/>
	HINDU <input type="checkbox"/>	JEWISH <input type="checkbox"/>	ROMAN CATHOLIC <input type="checkbox"/>
	MUSLIM <input type="checkbox"/>	SIKH <input type="checkbox"/>	NO RELIGION <input type="checkbox"/>
	PREFER NOT TO SAY <input type="checkbox"/>	OTHER <input type="checkbox"/>	
	IF "OTHER", PLEASE SPECIFY <input type="text"/>		
ETHNIC ORIGIN	ASIAN		
	BANGLADESHI <input type="checkbox"/>	CHINESE <input type="checkbox"/>	INDIAN <input type="checkbox"/>
	PAKISTANI <input type="checkbox"/>	OTHER <input type="checkbox"/>	
	<input type="text"/>		
	AFRICAN <input type="checkbox"/>	CARIBBEAN <input type="checkbox"/>	OTHER <input type="checkbox"/>
	WHITE <input type="checkbox"/>		
	EUROPIAN <input type="checkbox"/>	OTHER <input type="checkbox"/>	
	PREFER NOT TO SAY <input type="checkbox"/>		
IF "OTHERS" PLEASE SPECIFY <input type="text"/>			
DISABILITY	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
	IF "YES", PLEASE SPECIFY <input type="text"/>		
	<input type="text"/>		

HEALTH MONITORING

ONLY SUCCESSFUL APPLICANTS WILL BE REQUIRED TO COMPLETE A DETAILED MEDICAL QUESTIONNAIRE.

1. DO YOU HAVE ANY PHYSICAL OR MENTAL HEALTH CONDITIONS THAT MAY AFFECT YOUR PERFORMANCE FOR THE APPLIED POSITION?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. HAVE YOU BEEN REFUSED OR DISMISSED FROM ANY EMPLOYMENT BECAUSE OF HEALTH REASONS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. HAVE YOU PREVIOUSLY OR CURRENTLY UNDERTAKEN ANY MEDICAL OR THERAPEUTIC TREATMENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. ARE YOU ALLERGIC TO ANY CHEMICALS OR ANY OTHER SUBSTANCES? YOU MAY USE CLEANING CHEMICALS AT WORK.	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. ARE YOU PREGNANT?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. DO YOU HAVE ANY CONTAGIOUS INFECTION / DISEASE?	<input type="checkbox"/> YES <input type="checkbox"/> NO
7. ANY STRESS RELATED DISORDERS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. DO YOU REGULARLY ATTEND HOSPITAL FOR ANY MENTAL HEALTH CONDITIONS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. ARE YOU RECEIVING ANY MEDICAL TREATMENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO
10. ANY OTHER HEALTH, PHYSICAL OR MENTAL PROBLEMS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
11. HAVE YOU EVER LEFT EMPLOYMENT FOR HEALTH REASONS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
12. DO YOU WISH TO DISCUSS ANY ISSUES REGARDING YOUR HEALTH RELATED TO THE APPLIED POST WHICH YOU THINK IT IS A RISK TO CARRY OUT THE JOB ON YOUR OWN OR YOU MAY BE A RISK TO THE VULNERABLE SERVICE USERS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
13. THE CARE ASSISTANT JOB MAY INVOLVE HOIST AND MANUAL HANDLING SERVICE USERS. WOULD YOU BE ABLE TO DO THIS AFTER APPROPRIATE TRAINING WITHOUT ANY HEALTH RISKS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
14. ARE YOUR IMMUNISATIONS UP TO DATE? If not please contact your GP	<input type="checkbox"/> YES <input type="checkbox"/> NO
15. NUMBER OF DAYS SICKNESS ABSENCE IN THE LAST 2 YEARS:	<input type="text"/>

IF YOU HAVE ANSWERED YES TO ANY QUESTION ABOVE PLEASE EXPLAIN IN DETAIL BELOW, IF YOU WOULD LIKE TO NOTIFY US OF ANY OTHER HEALTH ISSUE YOU MAY HAVE PLEASE DO BELOW.

<input type="text"/>
<input type="text"/>
<input type="text"/>

SURGERY NAME	<input type="text"/>	SURGERY TELEPHONE NUMBER	<input type="text"/>
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DBS FORM AND BANK DETAILS

if you have subscribed online DBS service, please do not fill DBS form.

We charge £60 for DBS which is none-refundable. We advise you to register your DBS online once you receive it.

TITLE	Miss		FULL NAME		
COUNTRY OF BIRTH			BIRTH TOWN		
HAVE YOU CHANGED YOUR BIRTH SURNAME			<input type="checkbox"/> YES <input type="checkbox"/> NO		
IF "YES", PLEASE ENTER YOUR SURNAME AT BIRTH (EVEN IF IT IS THE SAME AS THAT ALREADY PROVIDED)					
SURNAME AT BIRTH					
Mother maiden name					
THE YEAR YOU CHANGE YOUR SURNAME?					
NATIONALITY AT BIRTH					
HAVE YOU CHANGED YOUR NATIONALITY SINCE BIRTH?			<input type="checkbox"/> YES <input type="checkbox"/> NO		
IF "YES", WHAT IS YOUR CURRENT NATIONALITY?					
PLEASE PROVIDE YOUR ADDRESS HISTORY COVERING THE LAST 5 YEARS INCLUDING OVERSEAS					
CURRENT ADDRESS				CITY	
POSTCODE				COUNTRY	
FROM DATE (MM/YYYY)				TO DATE (MM/YYYY)	
PREVIOUS ADDRESS 1					
CURRENT ADDRESS				CITY	
POSTCODE				COUNTRY	
FROM DATE (MM/YYYY)				TO DATE (MM/YYYY)	
PREVIOUS ADDRESS 2					
CURRENT ADDRESS				CITY	
POSTCODE				COUNTRY	
FROM DATE (MM/YYYY)				TO DATE (MM/YYYY)	

Bank Details For Wages

(Wage will be transferred to the above mentioned bank account and any error in the information provided will result in loss of pay and the company will not hold any responsibility.)

Name on account: _____ Name of the bank _____

Account Number: _____ Sort Code _____

By signing this form you agree

to provide personal care and support to Clients with a wide range of needs, illnesses and disabilities. Assisting with getting up in the morning and going to bed at night, wash, bath, shower, dress, undress, look after their skin, teeth, hair and nails, toileting, continence management, personal hygiene, support with their medication at the agreed level of support, prepare food and drink for the Client, being aware of the Client's choice, likes/dislikes, nutritional needs and cultural requirements and provide light general household domestic duties, including housework and laundry, as detailed in the care plan or instructed by Management

To use manual handling equipment safely and correctly, take responsibility for the safe handling of property and equipment belonging to the Client, maintain good communication and develop effective working relationships with Clients, provide companionship to the Client, actively talking and listening to them about their interests, help the Client to maintain contact with their family and friends, accompany the Client on trips into the community and to ensure as safe as possible the living environment for the Client, whilst respecting the Client's choice and Rights and payment.

DECLARATION: I declare that the information given on this form is to the best of my knowledge and correct

NAME		SIGNATURE	
DATE		For office use HR Signature	

We need following documents to process your application.

1. Passport
2. Visa or biometric if you don't have British or EEU passport
3. 2 proofs of address (utility Bill or bank statements etc. one letter should not be later than 3 months.)
4. National Insurance number Proof (NI card or any benefit letter)
5. Previous DBS (must be online registered, if not we will apply one for you and you will meet the cost
6. of £85
7. Training Certificates (if you have any)
8. P45 (if there is any) if you don't have from previous employer, we will give you P46 to fill. UTR
9. 2 referee details. (we will send the forms for referee to fill.)
10. Education or qualification evidence/certificate
11. University letter if you are overseas student
- Any other documentation to support your application

Further employment processing. We will contact your referees and apply for DBS if required. If you are a successful candidate you will be booked in for a training course which will be either in person or internet based. You will need to go for shadow training. We **DONOT** pay for any training or shadowing attended to as this is a requirement which you will need to meet.

If you wish to obtain a Care and Training Certificate there will be a charge for this as you will need to attend a full course

Please tell us in your words why you would like to work for Caring Hands

ADDITIONAL PAGE TO ENTER COMMENTS
PLEASE TO THE SECTION YOU WRITING ABOUT BELOW