SUPREME CARE SERVICES LTD
APPLICATION & REGISTRATION DOCUMENT CHECKLIST

CANDIDATE NAME:_____

POSITION BEING APPLIED FOR:_____

APPLICATION & REGISTRATION DOCUMENT CHECKLIST

Please ensure you provide the following documents for completion of your registration and application with Supreme Care

- ☐ Passport/Birth Certificate/Driver's Licence *
- ☐ Proof of Address (e.g. rent receipt, utility bill)
- ☐ Original certificates/diplomas/NVQ Qualification
- ☐ Certificates of training received in Domiciliary Care
- ☐ 2 passport photographs
- ☐ Bank/Building Society details
- ☐ CRB Enhanced Disclosure check
- ☐ National Insurance card/P45/P60
- ☐ Current Curriculum Vitae (CV)

* Only one of these items will be required for the purpose of identification.

Please also bear in mind the following when completing your application form and submitting the items required:

- Passport Photos
  Please ensure that you write your name at the back of your passport photos.

- Employment History
  Your employment history must be continuous, starting with your current or most recent employers; this must date back to the last five years. Any gaps in your employment history must be explained; you can note the explanation in the 'Duties and Responsibilities Section.

  If you need to continue your employment history on a separate sheet, please request an Employment History Continuation Sheet

- References
  You must provide two Professional Referees from your current or most recent employers. These Referees must have worked with you in a senior capacity and they should also be able to attach their company stamp or logo on the reference letter as well as be able to be contacted in order to verify that they completed the reference letter

SUPREME CARE SERVICES LTD

APPLICATION FORM

PERSONAL DETAILS

PLEASE COMPLETE IN BLOCK CAPITALS ONLY

SURNAME:	TITLE:	FORENAME:
PREFFERED NAME:		
OTHER NAMES BY WHICH YOU ARE KNOW:		
ADDRESS:		POST CODE:
TELEPHONE (HOME):	MOBILE:	
EMAIL ADDRESS:	DATE OF BIRTH :	
NATIONALITY:	NATIONAL INSURANCE NUMBER:	
ARE YOU ELIGIBLE TO WORK IN THE UK: YES ☐ NO☐		
IF YES, STATE VISA STATUS:	DATE OF ENTRY INTO THE UK: (DD/MM/YYYY)	

NEXT OF KIN DETAILS

NAME:		RELATIONSHIP:
ADDRESS:	MOBILE:	
	CONTACT #:	

OTHER LANGUAGE(S) SPOKEN:	
POSITION BEING APPLIED FOR:	
AVAILABILITY: Full Time ☐ Part Time ☐	
	DO YOU DRIVE YOUR OWN CAR? YES ☐ NO☐
Are you interested and available to do any of the following: LIVE-IN ☐ SIT-IN ☐ WAKE IN☐ SLEEP IN☐	

EXPERIENCE

Please indicate your areas of experience

☐NO EXPERIENCE/NEW TO HEALTH CARE
☐INCONTINENCE MANAGEMENT
☐MANAGING PEOPLE WITH TERMINAL ILLNESS
☐MANAGEMENT OF AGGRESSION
☐MANAGING PEOPLE WITH HIV/AIDS
☐MANAGING PEOPLE WITH LEARNING DIFFICULTIES
☐MANAGING PEOPLE WITH PEOPLE WITH SENSORY LOSS AND SENSORY IMPAIRMENT
☐MANAGING PEOPLE WITH MENTAL
☐MANAGING LIFTING & HANDLING EQUIPMENT
☐MANAGING PEOPLE WITH CHALLENGING & ANTI-SOCIAL BEHAVIOUR
☐MANAGING PEOPLE WITH PHYSICAL DISABILITIES
☐MANAGING PEOPLE WITH DEPRESSION
☐MANAGING PEOPLE WITH MENTAL HEALTH PROBLEMS INCLUDING DEMENTIA
☐MANAGING PEOPLE WITH ALCOHOL AND DRUGS MISUSE

EDUCATION AND TRAINING

Please give details of relevant training courses and /or qualifications that you have completed, starting with the most recent

ORGANISING BODY	COURSE TAKEN	FROM (mm/yyyy)	TO (mm/yyyy)	ATTAINMENT

EMPLOYMENT HISTORY

Please give details of all your previous employment (at least 5 years), starting with the most recent. You must give reasons for any gaps such as unemployment, voluntary work, and leave to raise family etc. (continue on a separate sheet if necessary)

EMPLOYER NAME AND ADDRESS:	DUTIES AND RESPONSIBILITIES:
POSITION HELD:	
DURATION EMPLOYMENT	
REASON FOR LEAVING:	

EMPLOYMENT HISTORY CONTINUED

EMPLOYER NAME AND ADDRESS:	DUTIES AND RESPONSIBILITIES:
POSITION HELD:	
DURATION EMPLOYMENT	
REASON FOR LEAVING:	

EMPLOYER NAME AND ADDRESS:	DUTIES AND RESPONSIBILITIES:
POSITION HELD:	
DURATION EMPLOYMENT	
REASON FOR LEAVING:	

EMPLOYER NAME AND ADDRESS:	DUTIES AND RESPONSIBILITIES:
POSITION HELD:	
DURATION EMPLOYMENT	
REASON FOR LEAVING:	

REFERENCES

Please detail **TWO PROFESSIONAL** referees from your current or most recent employment

Reference 1 NAME:	Reference 2 NAME:
POSITION:	POSITION:
ORGANISATION:	ORGANISATION:
ADDRESS:	ADDRESS:
CONTACT NUMBER:	CONTACT NUMBER:
EMAIL ADDRESS:	EMAIL ADDRESS:

BANK OR BUILDING SOCIETY DETAILS

FULL NAME
BANK ACCOUNT DETAILS NAME OF BANK
BRANCH
SORT CODE
ACCOUNT NUMBER
BUILDING SOCIETY DETIALS NAME OF BUILDING SOCIETY
BRANCH
SORT CODE
ACCOUNT NUMBER
BUILDING SOCIETY ROLL NUMBER

CONFIDENTIAL HEALTH QUESTINNAIRE

Please answer all the following questions by ticking the appropriate box. If your answer to any question is yes, please give further details.
All the information given in this form will be treated as confidential and will not be divulged to a third party without your consent.

SECTION A	Have you ever had any of the following?	
1.	Eczema, dermatitis or other skin condition	YES ☐ NO☐
2.	Discharge or infection of the ears or defects of hearing	YES ☐ NO☐
3.	Eye conditions or injuries or defects of sight	YES ☐ NO☐
4.	Asthma, hay fever or any other allergic conditions, including sensitivity to antibiotics	YES ☐ NO☐
5.	Recurrent sore throats or sinusitis	YES ☐ NO☐
6.	Recurrent sore throats or sinusitis	YES ☐ NO☐
7.	Tuberculosis, bronchitis or pneumonia	YES ☐ NO☐
8.	Episodes of severe chest pain or breathlessness	YES ☐ NO☐
9.	Heart disease or high blood pressure	YES ☐ NO☐
10.	Severe headaches	YES ☐ NO☐
11.	Fits, blackouts or epilepsy	YES ☐ NO☐
12.	Gastric or duodenal ulcers or frequent or prolonged indigestion	YES ☐ NO☐
13.	Hepatitis or jaundice	YES ☐ NO☐
14.	Prolonged back pain or disc problems	YES ☐ NO☐
15.	Arthritis or rheumatism	YES ☐ NO☐
16.	Difficulties in bending or lifting	YES ☐ NO☐
17.	Kidney or bladder infections	YES ☐ NO☐
18.	Diabetes	YES ☐ NO☐
19.	Varicose veins	YES ☐ NO☐
20.	Depression, mental illness or nervous breakdowns	YES ☐ NO☐
21.	Operations	YES ☐ NO☐
22.	Accidents (at work or elsewhere) requiring admission to hospital	YES ☐ NO☐
23.	Any other conditions requiring hospital treatment or investigation as an in-patient or out-patient	YES ☐ NO☐
24.	Absences from work or school due to ill health during the past year	YES ☐ NO☐

CONFIDENTIAL HEALTH QUESTINNAIRE CONTINUED SECTION B		
25. Are you currently taking or receiving any form of medication?	YES ☐	NO☐
26. Do you smoke?	YES ☐	NO☐
27. Do you drink alcohol?	YES ☐	NO☐
28. Are registered disabled or in receipt of a disability allowance?	YES ☐	NO☐
29. Do you normally wear glasses or contact lenses?	YES ☐	NO☐
30. How many days have you lost through sickness in the last year?	YES ☐	NO☐

If you have answered YES to any of the questions above, please use the space below to provide further details

NAME AND ADDRESS OF YOUR GP:

TELEPHONE NUMBER:

HEALTH DECLARATION
I know of no health reason that will affect my ability to undertake the duties required of me in the position for which I am applying. All the answers given on this form are true and correct to the best of my knowledge

Signature:	Print Name:	Date:

EQUAL OPPORTUNITIES POLICY

Supreme Care Services Limited is committed to promoting Equal Opportunities. Our policy is to ensure that job applicants and employees receive equal treatment irrespective of their race, colour, gender, age or disablement. By completing all sections of this form you will help us to monitor the effectiveness of our Equal Opportunities policy. All information will be held in strict confidence.

EQUAL OPPORTUNITIES POLICY – MONITORING CHECKLIST

For the purpose of monitoring our Equal Opportunities policy as stated above, please complete the following:

GENDER

Male☐ Female☐

NATIONAL/RACIAL ORIGIN

Asian	☐	Black	☐	White	☐
Pakistani	☐	African	☐	British	☐
Bangladeshi	☐	Caribbean	☐	European	☐
Indian	☐	British	☐	Other	☐
Other	☐	European	☐		
		Other	☐		

If you have selected 'Other', please detail

DISABILITY

Do you consider yourself as having a disability that could affect your day-to-day work?
YES☐ NO☐

If **YES**, please give details

DISCIPLINARY ACTION Have you ever been subject to any disciplinary action? YES☐ NO☐
If YES, please give details (use additional sheets if necessary)

HOME OFFICE CIRCULAR HOC 102/88

ALL APPLICANTS MUST ANSWER ALL QUESTIONS ON THIS FORM. FAILURE TO DO SO WILL INVALIDATE YOUR APPLICATION

In accordance with the above circular, you are required to provide the following information which will be passed on to the police authorities to check the existence and content of any criminal record.

Because of the nature of the work for which you are required, jobs and assignments are exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974 (Exemptions) (Amendments) Order 1986. Applicants are, therefore, not entitled to withhold information about convictions, reprimands or final warnings which, for other purposes, are 'spent' under the provisions of the Act and in the event of employment, any failure to disclose such convictions could result in removal from Supreme Care Services' list of employees.

Please note that this information will only be provided to and checked with the police authorities after a recruitment interview has taken place.

Please answer the following questions using BLOCK CAPITALS ONLY:	
Have you ever been convicted of a criminal offence, cautioned, sentenced, reprimanded or given a final warning by the police? YES☐ NO☐	
If YES, please give details (use additional sheets if necessary)	
FULL NAME:	
CURRENT ADDRESS:	
I HAVE LIVED AT THE ABOVE ADDRESS SINCE:	
PREVIOUS ADDRESS (must cover previous 5 years)	
DATE OF BIRTH:	PLACE OF BIRTH:
YOUR MAIDEN NAME:	
ANY OTHER IDENTIFYING PARTICULARS:	

WORKING TIME REGULATIONS

The European Union has laid down guidelines for all workers, governing maximum length of the working week for which it is safe to work. The current limit is 48 hours per week. You are under no obligation to accept work offered and you will never be compelled to work more than 48 hours per week but you may choose to do so.

Please sign below to confirm that you have read and understood this information, indicating your preference by ticking the appropriate option.

I have read this information regarding the Working Time Regulations and I understand that I do not have to work more than 48 hours per week

☐ 1. I DO NOT wish to work more than 48 hours per week

☐ 2. I DO wish to work more than 48 hours per week. I understand that I may withdraw this consent at any time by giving seven days notice to Supreme Care Services Ltd and signing a new form

Signature:	Print Name:	Date:

RIGHT TO WORK ENQUIRY AGREEMENT

I agree and give permission for Supreme Care Services Ltd to take appropriate action and contact the appropriate authorities as part of their efforts to validate my Right to Work in the UK.

Signature:	Print Name:	Date:

CONFIDENTIALITY AGREEMENT

I agree that during the time I am engaged by Supreme Care Services Ltd to work in any capacity:
1. I will not disclose to any person, any information obtained whilst attending an assignment.
2. I will hold in trust and confidence for Supreme Care Services Ltd, all such information, and never use it other than for the benefit of Supreme Care Services Ltd

Signature:	Print Name:	Date:

SUPREME CARE DECLARATION

If you provide false or misleading information to support your application it will disqualify you from being engaged as an employee by Supreme Care Services Limited.
If it is found that you provided false or misleading information to support your application after or during your employment, Supreme Care holds the right to terminate your contract on this basis.
I hereby declare that I have understood and complied with the requirements laid down in the application and I agree that the information given on this form may be used to obtain CRB check on me from the policy authorities.

Signature:	Print Name:	Date:

ADDITONAL NOTES
Please use this section to detail any further information that supports your application.

Signature:	Print Name:	Date:

FOR OFFICE USE ONLY

Reference 1

Sent: ☐Date: _____ Received: ☐Date:_____

Verification of Reference 1

Person Contacted: _____ Date: _____

Completed by: _____ Date:_____

Reference 2

Sent: ☐Date:_____ Received: ☐Date:_____

Verification of Reference 2

Person Contacted: _____ Date: _____

Completed by: _____ Date:_____

Relevant Immigration Documents seen: ☐Date:_____

Proof of NI seen: ☐ Date:_____ **Passport seen**: ☐ Date:_____

CRB payment: ☐ Date:_____ **CRB sent**: ☐ Date:_____

Uniform Issued: ☐ Date:_____ **ID Badge Issued**: ☐ Date:_____

Notes: