

Please bring the following items, and the completed list with you to interview, using the tick boxes to check off the items.

Documents Required	Tick
A completed HCA application form (<i>filled in completely with no gaps in work history</i>).	
A completed Declaration of Health questionnaire and written confirmation of all immunisations if available. We would encourage you to bring appropriate documentation, i.e. GP Card to prove all immunisations.	
Names and contact details for two professional references covering at least the past year. <i>NB. One must be from your current or most recent employer. References can only be sent to establishment addresses.</i>	
2 passport photographs (<i>recent and matching, signed and dated on the back</i>).	
3 forms of ID and proof of address . Please see the enclosed guide on acceptable forms of ID.	
One of the following original documents showing your National Insurance number: <ul style="list-style-type: none"> • A payslip from your previous employer • Your P60 • A letter from a government agency • A P45 	
Your P45, if applicable.	
Original certificate (preferable) or copies of any course or qualification you have completed during your professional career.	
Copies of any relevant training certificates completed within the past year (<i>if you are unable to provide evidence of any of the training below, we can arrange it</i>) <ul style="list-style-type: none"> • Manual Handling (evidence of a practical course) • Infection Control (including MRSA and C Diff) • Abuse Awareness (POCA and POVA) • Health and Safety (inc. COSHH and RIDDOR) • First Aid • Basic Food Hygiene • Fire Safety • Medication Training 	
Driving licence (<i>photo card and counterpart</i>), MOT & business insurance, if your role involves you using your car in the course of your duties.	
A cheque for £36.00 for your CRB Disclosure made out to Advantage Healthcare Group Limited (<i>This can be reclaimed via our FOR LIFE reward scheme once you are working</i>).	
Your bank account details (<i>if you do not have one we can help you set one up</i>).	
Overseas Workers A police check valid within the previous 3 months for overseas applicants who have entered the UK within the last 6 months.	

5 Professional details

To assist us in finding suitable work for you, please tick all the care tasks in which you are experienced:

Personal hygiene		Mobility		Practical tasks		Previous experience in:	
Bath/shower/strip wash	<input type="checkbox"/>	Moving and handling clients	<input type="checkbox"/>	Bedmaking/changing a bed	<input type="checkbox"/>	Hospital	<input type="checkbox"/>
Bed bath	<input type="checkbox"/>	Moving and handling course	<input type="checkbox"/>	Collecting benefits	<input type="checkbox"/>	Nursing home	<input type="checkbox"/>
Care of eyes	<input type="checkbox"/>	Use of hoists (man./elec.)	<input type="checkbox"/>	Cooking	<input type="checkbox"/>	Residential home	<input type="checkbox"/>
Care of feet (exc. toenails)	<input type="checkbox"/>	Use of walking aids	<input type="checkbox"/>	Light housework	<input type="checkbox"/>	Private house	<input type="checkbox"/>
Care of fingernails	<input type="checkbox"/>			Recording of blood pressure	<input type="checkbox"/>	Learning disabilities	<input type="checkbox"/>
Care of hair	<input type="checkbox"/>	Nutrition		Recording of temperature	<input type="checkbox"/>	Mental health	<input type="checkbox"/>
Dressing/undressing	<input type="checkbox"/>	Feeding	<input type="checkbox"/>	Recording of respiration	<input type="checkbox"/>	Children	<input type="checkbox"/>
Mouth care (inc dentures)	<input type="checkbox"/>	Food handling	<input type="checkbox"/>	Shopping	<input type="checkbox"/>	Prison services	<input type="checkbox"/>
Shaving	<input type="checkbox"/>	Preparing meals	<input type="checkbox"/>	Washing personal laundry	<input type="checkbox"/>		
Use of bath aids	<input type="checkbox"/>						
Toileting		Care Duties		Administrative abilities			
Applying a conveen	<input type="checkbox"/>	Assisting with medication	<input type="checkbox"/>	Confidentiality	<input type="checkbox"/>		
Attaching a night bag	<input type="checkbox"/>	Pressure area care	<input type="checkbox"/>	Observing/recording changes in clients' condition	<input type="checkbox"/>		
Bedpans/commodoes etc	<input type="checkbox"/>	Simple dressing procedures	<input type="checkbox"/>	Recording instructions from GP/District Nurse	<input type="checkbox"/>		
Changing a catheter bag	<input type="checkbox"/>	Terminal care	<input type="checkbox"/>	Report writing	<input type="checkbox"/>		
Continence care	<input type="checkbox"/>	Physical restraints skills	<input type="checkbox"/>	Makaton	<input type="checkbox"/>		
Emptying a catheter bag	<input type="checkbox"/>			Sign Language	<input type="checkbox"/>		
Stoma care	<input type="checkbox"/>						

Please explain briefly how you gained this experience

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**

Which areas of care do you have experience in?

Area	NHS/Private/Local Authority	Months/years	Level of proficiency		
			I	II	III
Nursing Home - Frail elderly - EMI - Other			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Home - Frail elderly - EMI - 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/Industry (specify area of work)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Level of practice	Date achieved
NVQ 1	
NVQ 2	
NVQ 3	

Please state if currently undertaking an NVQ course and at what level

Training received	Date	Certificate supplied
Manual Handling Adult <input type="checkbox"/> Paediatric <input type="checkbox"/>		
Infection Control (inc. C-diff and MSRA)		
Fire Safety		
First Aid		
Essential Food Hygiene		
Observation Skills		
Lone Worker		
Management of aggressive/violent behaviour		
Abuse Awareness POVA <input type="checkbox"/> POCA <input type="checkbox"/>		
Health and Safety (inc. COSHH and RIDDOR)		
Basic Life Support Adult <input type="checkbox"/> Paediatric <input type="checkbox"/>		
Medication Training Prompt <input type="checkbox"/> Assist <input type="checkbox"/> Administer <input type="checkbox"/>		
Skills for Care Induction Training		
Physical Restraints Training (please specify)		
Other, please specify		

6 General information

Do you hold a current driving licence? YES <input type="checkbox"/> NO <input type="checkbox"/>	Do you have a current passport? YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you have a car available? YES <input type="checkbox"/> NO <input type="checkbox"/>	Typing/WP experience? YES <input type="checkbox"/> NO <input type="checkbox"/>

Please state which languages you speak, including an indication of fluency

How did you first hear about this agency?

Are you a member of a Union or Professional Organisation offering Indemnity Insurance for carers? YES NO

Body name Amount of cover

Policy number Expiry date

7 Preference regarding work

Please specify which types of work you would prefer. You should tick all appropriate boxes. The service we give depends on accurate, up to date information. Please keep us informed of all developments, in your career and work preferences.

Positions part-time full-time

Type of work NHS private hospitals care home industry elderly children

Clients in their own home learning disabilities mental illness Other (please specify) _____

sleeper duties live-in days nights visits

Do you have any other work commitments? YES NO

Which areas of work do you wish to exclude?

When will you be available to start work?

10 Confidentiality declaration

Registration implies acceptance of our code of confidentiality.

In the course of your duties you may have access to confidential information about your clients. On no account must information relating to identifiable clients be divulged to anyone other than your branch manager or his/her assistant, without obtaining the Client's consent.

You should not disclose ANY information to your family, friends, or neighbours.

If you are worried by any information you have obtained and consider that you should talk about it to someone else MAKE AN APPOINTMENT TO SPEAK IN PRIVATE to your MANAGER.

Failure to observe these rules will be regarded as serious misconduct which could result in removal from the agency register.

I have read and I understand the above and I agree to abide by the contents therein.

Signed |

Date |

11 Passport and work permit details (for care workers from overseas only)

Work permit/visa

YES

NO

Expiry date |

Passport nationality |

Place of issue |

Passport number |

Date of issue |

Expiry date |

Known restrictions in use |

12 Declaration

The information that I have given in this application form is, to the best of my knowledge, complete and accurate in all respects, and I am not aware of any reason why I am not fit for this work. I understand that knowingly giving false information will disqualify me from registration with this agency.

Signed |

Date |

Name |

Position applied for |

Location |

Advantage Healthcare Group Ltd aims to be an equal opportunities provider of work and we select solely on merit irrespective of race, sex, disability etc. In order to monitor the effectiveness of our equal opportunities policy, we request all applicants to provide the information indicated. Please note: Ethnic minority questions are not about nationality, place of birth or citizenship. They are about colour and broad ethnic groups - UK citizens can belong to any of the groups indicated.

Please tick the appropriate category

White

Bangladeshi

Black African

Indian

Chinese

Black Caribbean

Pakistani

Black other please specify |

Other please specify |

Acceptable forms of Identification

Which documents do you need to provide?	
Can you produce any documents from Group 1?	
Yes	No
3 Documents must be seen. One document from Group 1 plus any two from Groups 1 or 2	5 documents must be seen Five documents from Group 2

Please note, all documents must be in your current name (marriage certificate excepted). At least one document must show your current address and at least one document must show your date of birth.

Group 1	
Passport	Any nationality
UK birth certificate	Issued within 12 months of date of birth – full or short form acceptable including those issued by UK authorities overseas, such as embassies, High Commissions and HM Forces.
UK Driving Licence	England / Scotland/ Northern Ireland / Isle of Man: either photo card or paper. A photo card is only valid if presented with the counterpart licence.
EU National Identity Card	EU countries only
HM Forces ID Card	(UK)
UK Firearms Licence	
Adoption Certificate	(UK)
Group 2	
Marriage / Civil partnership certificate	
Financial Statement	Eg pension, endowment, ISA issued within the last 12 months.
Birth Certificate	
Vehicle Registration Document	Document V5 old style and V5C new style only
P45 / P60 Statement (UK)	Issued within the last 12 months.
Mail Order Catalogue Statement	Within the last 3 months
Bank / Building Society Statement	Within the last 3 months
Court Claim Form (UK)	Document issued by Court Services
Utility Bill	Electricity, gas, water, telephone – inc. mobile phone contract / bill. Must be issues within the last 12 months.
TV licence	Must be issued within the last 12 months.
Addressed payslip	No more than 3 months old.
Credit Card Statement	No more than 3 months old.
National Insurance Card	(UK)
Store Card Statement	No more than 3 months old
NHS Card	(UK)
Mortgage statement	Issued within the last 12 months
Benefit Statement	i.e. Child Allowance, Pension. No more than 3 months old.
Insurance Certificate	Issued within the last 12 months
Certificate of British Nationality	(UK)
Council Tax Statement	(UK) Issued within the last 12 months.
Visa	(UK) Issued within the last 12 months.
A document from Central / local government / Government Agency / Local Authority giving entitlement (UK)	eg. Department for Work and Pensions, the employment Services, Customs and Revenue, Job Centre, Job Centre Plus and Social Security.
Connections Card	UK
CRB Disclosure Certificate.	Issued within the last 12 months.

Declaration of Health

Please complete both sides of this form carefully, writing clearly. Failure to give full details could cause delay in processing your application/continuing work. Please attach a separate sheet of paper if necessary.

1 Personal Details

Title	Surname	Forename(s)
Date of birth	Branch	
UK Address		
Post code	Telephone number	Mobile
GP name	GP Telephone number	
GP address		

2 Declaration of Health

Immunisations

Rubella	YES <input type="checkbox"/>	Date ____/____/____	NO <input type="checkbox"/>	Hepatitis B Injections	1st <input type="checkbox"/>	Date ____/____/____
BCG	YES <input type="checkbox"/>	Date ____/____/____	NO <input type="checkbox"/>	2nd <input type="checkbox"/>	Date ____/____/____	3rd <input type="checkbox"/>
Skin Test for TB	YES <input type="checkbox"/>	Date ____/____/____	NO <input type="checkbox"/>	Booster	1st <input type="checkbox"/>	Date ____/____/____
Tetanus	YES <input type="checkbox"/>	Date ____/____/____	NO <input type="checkbox"/>	2nd <input type="checkbox"/>	Date ____/____/____	3rd <input type="checkbox"/>
Chickenpox	YES <input type="checkbox"/>	Date ____/____/____	NO <input type="checkbox"/>	Date of last blood test		
Poliomyelitis	YES <input type="checkbox"/>	Date ____/____/____	NO <input type="checkbox"/>	Titre Result		
Diphtheria	YES <input type="checkbox"/>	Date ____/____/____	NO <input type="checkbox"/>	Date		
Other <i>please specify</i> _____						
Have you had Chickenpox?				YES <input type="checkbox"/>	NO <input type="checkbox"/>	

Pregnancy at work regulations

To protect your health at work please indicate, in confidence, to a member of staff if you are pregnant or breast feeding.

Further medical questions

Weight	Height
On the next page you are asked to provide information about a variety of conditions, please describe any other ill health circumstances	
Are you at present taking any medication or receiving any treatment? Give details for the last 12 months	
Please give details of sickness absence for the last 2 years	

Have you ever had problems with:	YES	NO	Please give details	Recovery complete	YES	NO
Raised blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Heart or circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Chest complaints e.g. Asthma, Bronchitis, Pleurisy, Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Chronic indigestion	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Bowel complaints	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Persistent abdominal pains	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Liver disease or jaundice	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, problems with thyroid or other glands	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy, Blackouts or dizziness	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Any mental health problems including: depression, psychiatric treatment, eating disorders or attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Have you received or are you receiving counselling	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Substance misuse including alcohol	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Persistent or recurrent backache or injury	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Neck injury/problems with neck	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Eczema, Dermatitis or other skin disease (Latex allergy)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Ear, nose or throat problems	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism, Arthritis or other joint problems	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Vision problems or eye disease	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Hay fever or allergies	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Any other serious illness	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Any operations	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Admissions to hospital	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Serious accidents/visits to casualty. If 'YES' how many times have you attended a casualty department in the last 3 years?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

Note: If there is a possibility that you may be suffering from an infection, you are requested to discuss this - in confidence with a member of the branch staff before taking up employment.

3 Declaration

I declare that I am fit for work and that all information is correct and accurate to the best of my knowledge.

Signature _____	Name _____	Date _____
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For office use only

1. Fit without restrictions <input type="checkbox"/>	3. Needs GP/specialist report <input type="checkbox"/>
2. Fit with restrictions (see below) <input type="checkbox"/>	

Restrictions/comments

1. Needs to clarify Hep B status <input type="checkbox"/>	4. Latex allergy <input type="checkbox"/>
2. Advise sees GP/Practice Nurse <input type="checkbox"/>	5. Other allergies: <input type="checkbox"/>
3. Needs to complete GP Authorisation Form (see HR Manual) <input type="checkbox"/>	_____

RGN Co-ordinator

Signature _____	Name _____	Date _____
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Need for Referral <input type="checkbox"/>	To whom _____	Date to review _____
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