

Welcome to Advantage Healthcare,

Thank you for your interest in registering with Advantage Healthcare Social Work, we look forward to this being the beginning of a long and mutually beneficial relationship.

This pack contains all you will need to know to register with us including.

- A registration form
- A declaration of health form
- 48 hour opt out agreement

We would be very grateful if you could complete the application form and return it to us, with the items outlined on the following page, as soon as possible so we can begin to look for an appropriate placement for you.

If you have a current CV prepared, please feel free to attach or e-mail this to us and note on sections 2, 3 and 4 of the application pack that details are enclosed in your attached CV.

We will return your items to you by special delivery and include a Criminal Records Bureau form, which we would be grateful if you could complete and return to you as soon as possible. As soon as we have your completed pack and items, we will begin searching our database and contacts for a suitable position.

We look forward to hearing from you and if you have any questions or queries, please do not hesitate to contact me on 01206 228 377 or e-mail [tarafry@advantagehealthcare.com](mailto:tarafry@advantagehealthcare.com).

I look forward to hearing from you.

Yours sincerely,

Tara Fry  
Operations Manager  
Social Work.

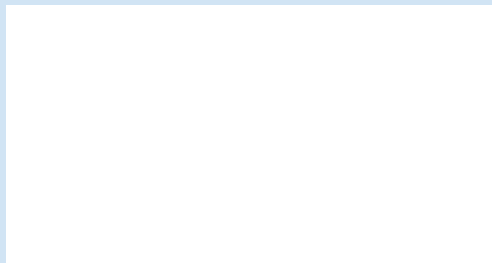
Please send the following items to us with your completed application form. We recommend using special delivery as you are able to track your documents).

- The completed registration form
- Copy of C.V.
- Completed declaration of health form
- Completed 48 hour opt out agreement
- Copy of your Social Work Qualification (original required)
- 2 x Proof of Identity i.e. Passport, Birth Certificate, Driving Licence (originals required)
- If available a copy of your current Police Check
- Recent proof of address i.e. bank statement, utility bill (originals required)
- Bank details
- Proof of N.I Number i.e. Payslip or N.I Card
- 3 Passport Photographs for us to be able to issue an Identity Card – Please print your name on the back of the photographs

**Advantage Healthcare Social Work**

3 The Atrium Phoenix Square Wyncolls road Severalls Business Park Colchester CO4 9AS  
Telephone: 01206 228 377 Fax: 01206 228 334 Email: [socialwork@advantagehealthcare.com](mailto:socialwork@advantagehealthcare.com)

Web: [www.advantagehealthcare.com](http://www.advantagehealthcare.com)



Attach  
photograph  
x 3

Agency Worker No

## Social work registration form

Please return your completed registration form to the address above

Please ensure all sections are completed in BLOCK CAPITALS.

### GSCC details

Please state qualification |

GSCC number (please enclose copy of registration certificate) |

Date of registration | | | | |

### 1 Personal details

Title | Surname | Maiden name |

Previous surnames (if any) |

Forenames (in full) |

Address |

Post code |

Telephone number |

Mobile |

Email address |

Nationality |

Date of birth | | | | |

National Insurance number |

**Next of kin to be notified in case of emergency** Name |

Address |

Post code |

Telephone number |

Relationship to you |

Work/mobile contact number |

### 2 Education

Details of education establishment	Courses taken	Date from	Date to	Attainment

### 3 Full working history

*Please print details of all your employment, to include all nursing agency membership, in reverse date order, starting with your present or last position. Please include reasons for gaps.*

Name & address of employer	Position(s) held, duties performed	Date from (incl. month)	Date to (incl. month)	Reasons for leaving
Present/last position				
<i>Please use additional sheets if you require more space.</i>				

### 4 Training eg. manual handling, CPR, infection control, first aid etc. (please provide certificates)

Details of training establishment	Courses taken	Date from	Date to	Attainment
Details of post qualifying training				

## 5 Professional details

*The service we give depends on accurate, up to date information. Please keep us informed of all developments in your career.*  
To assist us in finding suitable work for you, please tick all specialities of which you have significant, post training experience.

		Yrs exp.			Yrs exp.
<b>Children and Families</b>			<b>Older People</b>		
Child Assessment & Family Support	<input type="checkbox"/>	_____	Community	<input type="checkbox"/>	_____
Family Support	<input type="checkbox"/>	_____	Hospital Discharge	<input type="checkbox"/>	_____
Referral & Assessment	<input type="checkbox"/>	_____	Intermediate Care	<input type="checkbox"/>	_____
Child Protection	<input type="checkbox"/>	_____	Older Persons Review	<input type="checkbox"/>	_____
Immediate Need	<input type="checkbox"/>	_____	Assessment & Care Management	<input type="checkbox"/>	_____
Children in Need	<input type="checkbox"/>	_____	Dementia	<input type="checkbox"/>	_____
Looked After Children	<input type="checkbox"/>	_____	<b>Mental Health</b>		
Care Management	<input type="checkbox"/>	_____	Community Mental Health Team	<input type="checkbox"/>	_____
Leaving and After Care	<input type="checkbox"/>	_____	Assertive Outreach	<input type="checkbox"/>	_____
Adolescent Outreach	<input type="checkbox"/>	_____	Crisis Response & Home Treatment	<input type="checkbox"/>	_____
Child & Family Consultation Service	<input type="checkbox"/>	_____	Older Persons Mental Health	<input type="checkbox"/>	_____
Connexions	<input type="checkbox"/>	_____	Drug & Alcohol Teams	<input type="checkbox"/>	_____
Surestart	<input type="checkbox"/>	_____	Forensic	<input type="checkbox"/>	_____
Youth Offending	<input type="checkbox"/>	_____	Rehabilitation	<input type="checkbox"/>	_____
Children with Disabilities	<input type="checkbox"/>	_____	Child & Adolescent Mental Health	<input type="checkbox"/>	_____
Adoption	<input type="checkbox"/>	_____	Secure Accommodation	<input type="checkbox"/>	_____
Fostering	<input type="checkbox"/>	_____	<b>Other</b>		
Kinship Care	<input type="checkbox"/>	_____	Accident & Emergency	<input type="checkbox"/>	_____
Transition Care	<input type="checkbox"/>	_____	Specialist Hospital	<input type="checkbox"/>	_____
Form F's	<input type="checkbox"/>	_____	Hospice/Palliative care	<input type="checkbox"/>	_____
Court Work	<input type="checkbox"/>	_____	Disease Specific	<input type="checkbox"/>	_____
CAFCASS	<input type="checkbox"/>	_____	Charity	<input type="checkbox"/>	_____
TASCC Team	<input type="checkbox"/>	_____	MoD	<input type="checkbox"/>	_____
<b>Disabilities</b>			Housing	<input type="checkbox"/>	_____
Learning Disabilities	<input type="checkbox"/>	_____	Probation	<input type="checkbox"/>	_____
Physical Disabilities	<input type="checkbox"/>	_____	Any other skills _____		
Sensory Impairment	<input type="checkbox"/>	_____	_____		
Transition Work	<input type="checkbox"/>	_____	_____		

Please give details of experience in additional client groups / work settings |

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## 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? 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.*

<b>Positions</b>	part-time <input type="checkbox"/>	full-time <input type="checkbox"/>
<b>Type of work</b>	Children and families <input type="checkbox"/>	Physical Disabilities <input type="checkbox"/>
	Learning Disabilities <input type="checkbox"/>	Older people <input type="checkbox"/>
	Hospital <input type="checkbox"/>	Housing <input type="checkbox"/>
	Probation <input type="checkbox"/>	Mental Health <input type="checkbox"/>
<b>Place of work</b>	MOD <input type="checkbox"/>	NHS <input type="checkbox"/>
	Local Authority <input type="checkbox"/>	Charities <input type="checkbox"/>
	Private <input type="checkbox"/>	Industry <input type="checkbox"/>
	Prison Service <input type="checkbox"/>	

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?

Length of time available?

## 8 Convictions

**Rehabilitation of Offenders Act 1974:** State any convictions/offences, information of which you are not entitled to withhold, under the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975, in view of the nature of the work for which you are applying: \_\_\_\_\_

**Criminal Record Bureau/Disclosure Scotland Statement:** If your application is successful you will be required to provide a satisfactory Enhanced Disclosure or equivalent from country of origin if in the UK for less than three months. Advantage Healthcare Group Ltd will offer their full support through this process.

(This information will be disclosed by the Criminal Records Bureau/Disclosure Scotland check which will be required if your application is successful)

## 9 References

*Please give the names of referees, to whom you have reported, including your present or most recent employer, whom we may approach for a reference. A minimum of three years history must be covered.\* (Business address to be given).*

*\*Referees must be a previous/current supervisor/manager or employer and cover your last three years work. Please also ensure you include one character reference.*

Can we contact your referees before your interview?

1. YES  NO  2. YES  NO

3. YES  NO  4. YES  NO

<b>1st Referee</b>	Name _____	Position _____
Company name _____		
Address _____		
Post code _____		Telephone number _____
		Email _____
		Known me for _____ years
<b>2nd Referee</b>	Name _____	Position _____
Company name _____		
Address _____		
Post code _____		Telephone number _____
		Email _____
		Known me for _____ years
<b>3rd Referee</b>	Name _____	Position _____
Company name _____		
Address _____		
Post code _____		Telephone number _____
		Email _____
		Known me for _____ years
<b>4th Referee</b>	Name _____	Position _____
Company name _____		
Address _____		
Post code _____		Telephone number _____
		Email _____
		Known me for _____ years

## 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.*

*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 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 work provider 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

Black African

Bangladeshi

Indian

Chinese

Black Caribbean

Pakistani

Black other  please specify |

Other  please specify |

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

#### 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"/>		
<b>Restrictions/comments</b>			
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
Need for Referral <input type="checkbox"/>	To whom	Date to review

# OPT-OUT OF 48 HOUR WORKING WEEK AGREEMENT

## 1. DEFINITIONS

1.1 In this Agreement the following definitions apply:-

“Worker”	Agency Member
“Working Week”	means an average of 48 hours each week calculated over a 26 week reference period.

1.2 References to the singular include the plural and references to the masculine include the feminine and vice versa.

1.3 The headings contained in this Agreement are for convenience only and do not affect their interpretation.

## 2. RESTRICTION

2.1 The Working Time Regulations 1998 provide that the Worker shall not work in excess of the Working Week unless he agrees in writing that his limit should not apply.

## 3. CONSENT

3.1 The Worker hereby agrees that the Working Week limit shall not apply.

## 4. WITHDRAWAL OF CONSENT

4.1 The Worker may end this Agreement by giving 3 months notice in writing.

4.2 For the avoidance of doubt, any notice bringing this Agreement to an end shall not be construed as notice of termination by the Worker.

4.3 Upon the expiry of the notice period set out in clause 4.1 the Working Week limit shall apply with immediate effect.

## 5. THE LAW

5.1 These Terms are governed by English and Scottish law and are subject to the exclusive jurisdiction of the English and Scottish Courts.

Signed by the Worker: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print name: \_\_\_\_\_