APPLICATION FORM

Position Applying For

Personal Particulars

Prefix *

○ Mr. ○ Ms ○ Mrs. ○ Miss

Full Names *

First Name Middle Name Last Name

Marital Status *

○ Single ○ Married ○ Divorced ○ Widowed

Date Of Birth *

Day Month Year

Country Of Birth *

Nationality *

National Insurance Number *

Bank Details

Bank Name

Address

Street Address

City

State / Province

Sort Code

Account Number

All details are held in the strictest confidence under the Data Protection Act 1998. I authorise BetaCare to make payments to this account for work done *

I Agree

Date

Month Day Year

Residential Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Home Tel. No.

Mobile Tel. No. *

Email *

example@example.com

Fax No.

Correspondence Address (If different from above)

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Educational Qualifications

Professional Qualifications

Proficiency In Languages

Native Language

Second Language (optional)

Proficiency In Speaking Second Language

Proficiency In Writing Second Language

Proficiency In Reading Second Language

Third Language (optional)

Proficiency In Speaking Third Language

Proficiency In Writing Third Language

Proficiency In Reading Third Language

Do You Hold a Full Uk Driving License Or Equivalent

- Yes
- No

Details Of Any Endorsement

Do You Have A Car?

Yes

No

Skills (Nursing)

Skills (Others)

References

Health Questionnaire

An answer must be provided for all questions. The information will be treated in confidence.

GP Name:

First Name Last Name

GP Address:

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

GP Tel Number

Medical History

Please complete the following questions by ticking the appropriate box. If the answer is 'yes', give details including (a) date, (b) amount of time lost from work/school, (c) treatment, as appropriate.

Have you ever suffered from any of the following illnesses?

Visual defects/eye conditions (including colour-blindness)

Yes

No

If yes please provide details

Hearing defects/ear conditions

Yes

No

If yes please provide details

Severe anxiety, depression, other psychiatric disorder

Yes

No

If yes please provide details

Paralysis or other neurological disorder

Yes

No

If yes please provide details

Fainting attacks, blackouts, epilepsy or fits

Yes

No

If yes please provide details

Fainting attacks, blackouts, epilepsy or fits

Yes

No

If yes please provide details

Recurrent headaches, migraine

Yes

No

If yes please provide details

Vertigo, giddiness or tinnitus

Yes

No

If yes please provide details

Heart disease, high blood pressure

Yes

No

If yes please provide details

Asthma, bronchitis, tuberculosis or other chest disease **I**

Yes

No

If yes please provide details

Peptic ulcer or other digestive or bowel disorder

- ○ Yes
- ○ No

If yes please provide details

Liver disorder

- ○ Yes
- ○ No

If yes please provide details

Kidney of bladder problems

- ○ Yes
- ○ No

If yes please provide details

Gynecological problems

- ○ Yes
- ○ No

If yes please provide details

Recurrent backache, arthritis, rheumatism

- ○ Yes
- ○ No

If yes please provide details

Any blood disorder

- ○ Yes
- ○ No

If yes please provide details

Any blood disorder

- ○ Yes
- ○ No

If yes please provide details

Eczema, dermatitis, other skin conditions

- ○ Yes
- ○ No

If yes please provide details

Diabetes, thyroid or other gland problems

○ Yes ○ No

If yes please provide details

Hayfever, allergies to drugs, animals etc

○ Yes ○ No

If yes please provide details

Any recurrent infections

○ Yes ○ No

If yes please provide details

Any impairment of immunity to infection

- ○ Yes
- ○ No

If yes please provide details

Varicose veins causing trouble

- ○ Yes
- ○ No

If yes please provide details

Hernia

- ○ Yes
- ○ No

If yes please provide details

Any alcohol or drug related problems or illness

- ○ Yes
- ○ No

If yes please provide details

Any other medical condition, physical or mental, not mentioned above

- ○ Yes
- ○ No

If yes please provide details

Have You Ever

Ever undergone a surgical operation or been admitted to hospital for any reason?

- ○ Yes
- ○ No

If yes please provide details

Had more than 20 days sickness absence in the past 2 years?

- ○ Yes
- ○ No

If yes please provide details

Ever been, or are a Registered Disabled Person?

- ○ Yes
- ○ No

If yes please provide details

Received a Disability Pension?

- ○ Yes
- ○ No

If yes please provide details

Suffered from an Industrial Disease/Accident?

- ○ Yes
- ○ No

If yes please provide details

Had a chest X-ray in the past 12 months – If so state place / date / result

- ○ Yes
- ○ No

If yes please provide details

PRESENT HEALTH STATUS

Had a chest X-ray in the past 12 months – If so state place / date / result

Yes

No

DBS Online Application

BetaCare Healthcare DBS Check

Follow the link:- www.dbsdirect.co.uk

Then click on – **Mayflower Disclosure Services Ltd**
and Application log in:(Orange box)
Organization Reference: BETACARE
Organization Code: BETACARE

Supporting Statement

Please state why you believe you are a suitable candidate for this post by explaininghow you meet the requirements of the job description and the experience youhave gained which is relevant. Please give examples of particular achievements

Additional Information

Earliest Date Available If Appointed

Have you had any criminal convictions (including spent convictions under the rehabilitation of offenders Act 1974)?

- ○ Yes
- ○ No

Are you subject to any restrictions from previous employers which may restrict your working activities?

- ○ Yes
- ○ No

Have you ever been employed by this company or its affiliates before?

- ○ Yes
- ○ No

Have you applied for employment with this company before?

- ○ Yes
- ○ No

Are you related to any employee working at this company?

- ○ Yes
- ○ No

Do you have any physical impairment or health problem?

- ○ Yes
- ○ No

Have you been dismissed or suspended from the service of any employer?

- ○ Yes
- ○ No

Are you bound by any bond to serve the government, or any organisation?

- ○ Yes
- ○ No

If yes to any of the above, please give details here

Interview Questionnaire

Full Names *

First Name Last Name

Position Applied For

What are your strengths?

What are your weaknesses?

What are your goals?

What makes you a good candidate for this job?

If you encountered a service user who was upset what would you do?

If you encountered a service user who was being aggressive towards you or another resident how would you deal with it?

How would you transfer a resident from a bed to a wheelchair?

What is a care plan? Why should it be kept up-to-date?

What is the purpose of a hand-over?

Describe what you would do if a service user were to have an accident? Who would you report this to?

What does 'Promoting Independence' means?

How would you promote infection control?

What items do you use to prevent the spread of infection?

How would you dispose of clinical waste?

What would you do if you witnessed another employee stealing?

What would you do if witnessed another employee being aggressive with a service user?

What would you do if you witnessed another employee not abiding by health, safety and infection control policies?

What would you do if you were uncertain of what to do on a shift?

What would you do if you did not understand or felt you didn't have enough training in certain areas of mandatory expectations?

You confirm that everything completed in this section is correct and attest to your character? *

☐ Yes, I agree

Date *

Month Day Year

Terms Of Engagement

Contract For Services

Thank you for applying to BetaCare website (the "Site"). These terms & conditions ("Terms and Conditions") apply to the Site and its application service which reference these Terms and Conditions. Kindly review the Terms and Conditions listed below diligently prior to submitting this form as your submission on this website indicates your agreement to be wholly bound by its Terms and Conditions without modification.
You agree that if you are unsure of the meaning of any part of these Terms and Conditions or have any questions regarding the Terms and Conditions, you will not hesitate to contact us for clarification.

Click here to review.

Temporary Worker's Full Names *

First Name Last Name

You acknowledge that you have read and agreed to the terms and conditions of the contract attached herewith? *

☐ Yes, I agree

Date *

Month Day Year

Declaration

I certify that all entries are true and correct. I understand that all information on this application is subject to verification. I agree and understand that, in the event of my employment by BetaCare, I shall be subject to dismissal if any information that I have given in this application is false or misleading, regardless of time of discovery. I undertake to notify BetaCare of any changes in my circumstances, including health, criminal convictions and driving license endorsement, which would or could affect my ability to work. I understand that BetaCare may release my personal details to a client in order to secure work or to enable the client to verify my identity or eligibility to work. These details may include name, age, driving license, work history, criminal record, health questionnaire and proof of identity or eligibility to work. I authorize the BetaCare to inquire into my educational, professional and past employment history references as needed to research my qualifications for this position. I hereby give my consent to any former employer to provide employment-related information about me to the Company and will hold the Company and my former employer harmless from any claim made on the basis that such information about me was provided or that any employment decision was made on the basis of such information. I hereby acknowledge that I have read and agree to the above statements

Date *

Month Day Year