

Application form

Post applied for: Carer Support Worker

Please complete in black ink or type

Personal details – Part A

Preferred title:	First name:
Surname/family name:	
Address:	
Post code:	
E mail address:	
Tel. (home):	Tel. (work or mobile):

References please give names, addresses and telephone numbers of two people who can provide references for you. They **must** be your last two employers. If you are not currently in employment please see the enclosed guidelines on completing this form. Crossroads reserves the right to contact other previous employers. We do not approach referees until after interview.

Present or previous employer	
Name:	Name:
Job title:	Job title:
Organisation:	Organisation:
Address:	Address:
Telephone:	Telephone:
E mail address:	E mail address:
How is this referee known to you?	How is this referee known to you?
Do you wish to be contacted before we approach this referee? Yes/No	

Rehabilitation of Offenders Act 1974 and Exception Order 1975

Because of the nature of the work for which you are applying, you must provide information about any criminal record. This includes convictions, cautions, reprimands and final warnings. Our power to require this lies in the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 which removes the normal operation of the Act in relation to specific occupations, including the provision of Home Care Services. In the event of being employed in connection with this application, any failure to disclose such convictions could result in dismissal or disciplinary action.

If you have no convictions please write NONE

If you do have any previous or outstanding convictions, cautions, reprimands or final warnings, you will only be asked to supply details of the type of offence, date, sentence, fine etc if you are invited for interview. Please see guidelines on completing the application form for further details.

Sickness absence

How many days sickness absence have you had over the last two years?

Declaration

I declare that all the information I have given on this application form is true and accurate, to the best of my knowledge. Please note that if you give untrue or inaccurate information any employment contract may be invalidated and the employee subject to disciplinary action or dismissal.

Signed: **Date:**

If you downloaded your application from the internet please print it off and sign.

Section A will be detached from your application. All short listing will be carried out on a completely fair basis with Equal Opportunities Legislation and Policy



Application form

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Please complete in black ink or type

Education & work history – Part B

Education and qualifications

Please tell us about the school/college/university you attended, starting with the most recent

Name of school/ college/university	Dates you started and finished	Qualification and grade

Training please tell us about any relevant training courses

Course title and content	Organisation that ran training	Date training attended

Present or most recent employment

Employer's name and address:	
Dates of employment including month and year:	
Post title:	Reason for leaving:
Please tell us about what you did in your job:	
Notice required:	Salary:

If you need more space for any of these sections please continue on a separate sheet

Do you hold a current UK driving licence? Yes/No

Do you have your own transport? Yes/No

Past employment please give details of your entire work history. You do need to account for any gaps in employment.

Employers name and address:	Dates from & to month & year:	Job title & brief description of duties:	Reason for leaving:

If you need more space please continue on a separate sheet of paper

Information in support of your application please use this space to tell us how your skills, experience and knowledge match those in the job description and person specification.

If you need more space please continue on a separate sheet of paper



CHESHIRE WEST & WIRRAL

	Early Morning	Morning	Mid-day	Tea-time	Evening
Mon-Fri					
Saturday					
Sunday					
Bank Holiday					

Crossroads aims to offer help anytime during the day or evening to suit individual needs of the families. Please tick in the boxes below the times that you could work.

Signature _____ Date / /

THIS FORM SHOULD BE RETURNED TO:

**Sheila Logan
Registered Care Manager.
Crossroads Care Cheshire West
& Wirral
G.F 2 Candy Park
Old Hall Road
Bromborough
Wirral
CH62 3PE**

Registered Charity No. 1046953

ET.02b

Equal Opportunities Monitoring Form

This questionnaire will not be seen by the recruitment panel. All information received will be treated in strict confidence. Crossroads Care strives to be an equal opportunities employer and has a clear policy in terms of challenging discriminatory practices. In order to have accurate information about our performance we would be grateful if you would complete this monitoring form and return it with your application form. If you feel that our recruitment procedure has unfairly discriminated against your application to work with us, please take this opportunity to tell us.

Post applied for:

1	How would you describe your ethnicity?			
	White		Asian or Asian British	
	British	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>
	Irish	<input type="checkbox"/>	Indian	<input type="checkbox"/>
	Any other white background <i>(please specify:)</i>	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
			Any other Asian background <i>(please specify:)</i>	<input type="checkbox"/>
	Black or Black British		Mixed	
	African	<input type="checkbox"/>	White and Black Caribbean	<input type="checkbox"/>
	Caribbean	<input type="checkbox"/>	White and Black African	<input type="checkbox"/>
	Any other black background <i>(please specify:)</i>	<input type="checkbox"/>	White and Asian	<input type="checkbox"/>
			Any other mixed background <i>(please specify:)</i>	<input type="checkbox"/>
	Chinese		Other ethnic group	
	Chinese	<input type="checkbox"/>	Other ethnic group <i>(please specify:)</i>	<input type="checkbox"/>
	If you would like to further describe your ethnicity, please do so here:			

2	Which age category do you fit into?			
	18 - 24 years	<input type="checkbox"/>	49 - 56 years	<input type="checkbox"/>

	25 - 33 years	<input type="checkbox"/>	57 - 65 years	<input type="checkbox"/>
	34 - 40 years	<input type="checkbox"/>	66 - 70 years	<input type="checkbox"/>
	41 - 48 years	<input type="checkbox"/>	Over 70 years	<input type="checkbox"/>
3	Are you male or female?			
	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>
4	Do you consider yourself to be a person with a disability? This includes people with long term health conditions. If you tell us you have a disability we will make reasonable adjustments to where you work and to your work arrangements and at interview.			
	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
5	Are you a carer? "A carer is someone, who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability."			
	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Please tell us how you heard about the job you are applying for so we can find out how good our advertising is

Newspaper (which one) Web site (which one)

Other (please give details)

ET.11

Fitness for Employment: Medical Questionnaire

STRICTLY PRIVATE AND CONFIDENTIAL

Completed form to be returned by shortlisted applicant in a sealed envelope on the **day of interview**

Name in full: **Title**.....

Maiden or previous Surname(s).....

Date of birth..... **Age**.....

Address.....

.....

.....

Telephone No

Proposed appointment.....

MEDICAL INFORMATION

Height without shoes..... **Weight** in indoor clothing.....

If you have suffered from any of the following, write 'YES' in column (i) and give the date in column (ii). If the answer is 'NO' please write 'NO' in column (i) opposite each item.

EVERY QUESTION MUST BE ANSWERED 'YES' OR 'NO'.

		(i) Yes/No	(ii) dd/mm/yy
1	Tuberculosis of the lung or other part of the body		
2	Asthma or hay fever or other allergic conditions(including allergies to animals etc).		
3	Any other disease of the lung e.g. Pleurisy, bronchitis, pneumonia		
4	Rheumatism or arthritis		
5	Heart disease		
6	Disease of the nervous system		
7	Epilepsy, convulsions, blackouts, attacks of fainting or dizziness		
8	Any form of mental illness or nervous breakdown		
9	Hernia		
10	Back trouble or back injury		
11	Any other disabling condition or disabling incapacity		
12	Typhoid or paratyphoid, glandular illnesses		
13	Dysentery		
14	Other significant ailments of stomach, bowels or digestive system		
15	Any disease of kidneys or bladder or liver or reproductive organs		
16	High blood pressure		
17	Skin diseases, skin rashes and allergies		
18	Frequent sore throats, tonsillitis, ear infections		
19	Diabetes		
20	Blood disorders, ie pernicious or other severe anaemia		
21	Migraine, headaches		
22	Varicose veins		
23	Tropical diseases, such as, Malaria, Legionnaires disease		

(See also Question c below)

QUESTION	YOUR RESPONSE
a If there is an answer 'YES' to any of the previous questions, please provide further details, e.g. duration of illness, nature of treatment, nature of allergy, date of return to work, any further attack etc	
b Are there any defects in your sight or hearing? If so, give details and state whether it has been corrected, e.g. by glasses or hearing aid?	
c Have you ever had any serious accident or operation or suffered from any severe illness not listed? Please specify and give dates	
d Are you currently taking medication (other than for contraceptive purposes)? If so - (i) What (ii) For what purpose	
e Do you ordinarily enjoy good health?	
f Have you during the last five years had any absences from work because of illness (including injury of other disability) totalling ten days or more in any one year? If so give particulars	
g Have you ever had a chest X-ray (including mass radiography)? If so: (i) for what reason? (ii) when (month, year)? (iii) where? (iv) with what result?	
h Do you have a disability? If so, please state disability	
i Have you any reason to believe you would be refused entry to a sickness / pension fund or refused life assurance?	
j Have you left any previous occupation or been rejected on any application for employment on medical grounds?	
k Please give the name, address and telephone number of your own General Practitioner.	
l And the name of any consultant who has treated you during the past three years	

QUESTION	YOUR RESPONSE
m Are you immune to TB by virtue of having been immunised against it or having had a Mantoux, Tine or Heaf test or been advised not to be immunised? If you are unsure or cannot remember, then answer NO Skin test (year) & Result BGG immunisation.(year) & Result	
N Have you been immunised against (a) Poliomyelitis?.Yes / No.(Year) (b) Tetanus? Yes / No.(Year) (c) Rubella (German Measles) Yes / No.(Year) (d) Hepatitis B? Yes / No.(Year)	

DECLARATION

I declare that I have answered the above questions honestly and fully and that I am not otherwise aware of any physical or mental disability which will, or may, affect my working capacity. I realise that, if appointed, any false or incomplete statement on my part will render me liable to dismissal. I agree to make myself available for a medical examination by a suitably qualified practitioner at Crossroads Care expense if it is felt details disclosed in the document warrant further investigation in the light of the vacancy for which I am being considered. I agree that a report on my fitness for employment be made to the appropriate Manager.

If it is necessary for Crossroads Care to communicate with my own Doctor and / or consultant who has treated me, I authorise them to reply to any query concerning my health or medical history. Likewise, I agree to my doctor being informed of the results of any tests taken, which Crossroads Care considers should be brought to my doctor's attention.

If it is discovered that I have an illness or disability, the details of which should be made known to my potential employer in confidence for my own safety or that of other members of the staff, or clients I authorise the examining medical officer to disclose to my potential employers such details as he/she may consider necessary.

SIGNATURE.....

DATE.....

Please return this form to Crossroads Care in a sealed envelope.