dt care services
DIVINE TOUCH, CARE FROM THE HEART

Passport Photos
X2

Job Application Form

MR/MRS/MISS/ MS (please delete as appropriate)	
FIRST NAME:	
MIDDLE NAME:	
SURNAME:	
DATE OF BIRTH:	
NATIONAL INS.NO.	
ADDRESS	
POSTCODE:	
HOME TEI·	
MOBILE:	
E-MAIL:	
MARITAL STATUS:	
NEXT OF KIN:	
RELATIONSHIP:	
ADDRESS:	
POSTCODE:	
PHONE NUMBER:	
DO YOU HAVE PERMISSION TO WORK IN THE UK?	YES/ NO
DO YOU HAVE A VALID PASSPORT?	YES/NO
YOU HAVE A VALID WORK PERMIT?	YES/ NO
DO YOU HOLD A FULL UK DRIVING LICENCE?	YES / NO

QUALIFICATIONS/TRAINING

Qualifications	School/College	Grade/Result	Dates: From-To

Relevant Training/Qualifications in Health care:		Certificates Date:
Manual handling	YES/NO	
Health and safety	YES/NO	
Basic food hygiene	YES/NO	
First aid	YES/NO	
NVQ levels	YES/NO	
Others (please list)	YES/NO	

EMPLOYMENT HISTORY/WORK EXPERIENCE

Please record all employment in the past 5 years, including current employment by other agencies, and any other relevant experience gained within the health care field. Please start with the most recent. Please note that we shall obtain a reference from your LAST EMPLOYER

Employer Name, Address &Tel no.	From	To	Position held, Duties and Responsibilities	Reason for Leaving
	..			
PLEASE DECLARE GAP IN EMPLOYMENT AND REASON:				

REFERENCES

1a) Must be your most recent employer (of at least 3 months duration) whichmust correspond with your employment history.
Name of Employer. Address of employer. Telephone Number E-mail. Fax Number.
1b) Another of your Employers in the last 3 years:
Name of Employer. Address of employer. Telephone Number. E-mail..... Fax Number.
2) Must be a fellow health care professional who does not live with you and is able to supply a character Reference of your personal and professional profile.
Name of Employer..... Address of employer. Telephone Number. E-mail..... Fax Number.

HEALTH DECLARATION

Carers/Support workers. are required to complete this Health Declaration.Any positive answers will not necessarily affect your application. Please list any medical. conditions (past or present) which may affect your ability to do the job.

Occupational Health Assessment	Yes	No	Details
Are you in good health?			
How much time have you lost from work due to illness in the last five years? Please provide details			-
Have you ever been treated in hospital for serious illness or surgery? Please give dates			
Have you been treated in hospital during the last 12 months?			
Do you have any physical disabilities that could affect your ability to carry out your assignment?			
Have you ever left,been retired or denied a job on health grounds?			
Have you ever been denied a driving licence on health grounds?			
Are you a registered disabled person?			
Have you any disability related to your physical or mental health?			
Have you ever suffered from any mental illness,psychological or psychiatric problems?			
Do you get discomfort or pain in the chest or shortness of breath on exercise?			
Have you ever had any problems with your joints, including pain, swelling or stiffness?			
Do you have any difficulty in moving rapidly over short distances? .			
Would you have difficulty looking over either shoulder?			
Do you need to wear glasses or contact lenses?			
Do you have any difmiculty with your eyesight which is not correcled by glasses or -- contact lenses?			
Have you any problems working with Visual Display Units?			
Have you any probloms working in confinod cpacos/using ifte?			
Do you have any difficulty hearing normal conversation?			
Are you taking any medication that makes you dizzy or drowsy?			

Do you have a medical condition affected by changing sleeping pattems or affecting daytime sleep?			
Have you suffered from any alcohol or drug related illness or had an alcohol or drug problem?			
Are you having or awaiting any treatment at the moment?			
What is the date of your last chest x-ray?			
Are you receiving Medicines, Pills or Tablets from a doctor or on prescription?			
Have you ever suffered from any of the following?			
Heart Problems/Circulatory Hlness/Hypertension			
High or Low Blood Pressure			
Diabetes			
Asthma/Hay fever			
Bronchitis/Pneumonia/Pleurisy			
Tuberculosis			
Epilepsy/Fainting Attacks/Blackouts/Fits/Sudden Collapse			
Headaches/Migraine			
Psychiatric Illness/Anxiety/Depression			
Dermatitis/Skin Sensitivity/Psoriasis/Eczema/Allergies			
Back Injury/Back Problems/Back Pains			
Recurrent Infections e.g.Sore Throats/Ear Infections/Eye Infections			
Hepatitis/Jaundice			

Have you ever been Vaccinated, Immunized or Tested for /against any of the following?	YES/NO	DETAILS
Tuberculosis incl BCG, Heaf,Mantoux or Tine		
Rubella (German Measles)		
Poliomyelitis		
Hepatitis B		
Hepatitis B Anitbodies Date and Result		
HIV		
Tetanus		
Typhoid		
Any Other		
DOCTOR INFORMATION		
GP Name: Address: Postcode: Phone:		

WORK PREFERENCE

To assist us in finding suitable work for you, please place a tick next to all specialties of which you have significant recent experience and are confident to carry out such duties.

Please keep us informed from time to time of all developments in your career as the work we assign to you depends on accurate up to date information.

WORK PREFERENCE: (Please tick).	
Full time/Part time, If part time, how many hours per week do you want to work... Home care and pop-in visits Hospitals Nursing/Residential Homes Morning/Day/Evening/Night Sleeper duty	
Live-In Care	
Please state if you are able to work as a 24-hour Residential(live-in) Carer. If YES, would you like: YES/NO. Long.....or short.....assignments? Would you accept a live-in assignment some distance from your home? YES/NO If NO, please specify preferred areas:	

Care/Support Assistant ability schedule

Please indicate yes/No in the areas you have had previous experience.

Personal hygiene		Care duties	
bath/shower/strip wash	Yes/No	Pressure area care	Yes/No
bed bath	Yes/No	Simple dressing procedure	Yes/No
Use of bath aids	Yes/No	Assisting with medication	Yes/No
Shaving	Yes/No	Terminal care	Yes/No
Mouth care(inc.dentures	Yes/No		
Care of hair	Yes/No	Practical tasks	
Care of feet(exc.toe nails)	Yes/No	Light house work	Yes/No
Care of finger nails	Yes/No	Washing personal laundry	Yes/No
Dressing/undressing	Yes/No	Shopping	Yes/No
		Bed making/changing bed linen	Yes/No
Toileting		Collecting benefits	Yes/No
Continence care	Yes/No		Yes/No
Bedpans/commodes etc.	Yes/No.	Admin.Abilities	
Changing a catheter bag	Yes/No	Confidentiality	Yes/No
Empting catheter bag	Yes/No	Report writing	Yes/No
		Recording instructions from GP/DISTRICT NURSE	Yes/No
Mobility		Observing/recording	Yes/No
Maneuvering and handling course	Yes/No	Changes in clients condition	Yes/No
Use of hoists(man./elec)	Yes/No	Previous exp.	
Use of walking aids	Yes/No	Private house	Yes/No
		Nursing/residential Home	Yes/No

EQUAL OPPORTUNITIES MONITORING

DT Care Services aims to be an equal opportunities employer. Employees are therefore put forward for work/shift irrespective of race, ethnic origin, disability, age and gender. To monitor the effectiveness of our policy, we request all candidates to provide the following information.

Name				
Age Group	16-200	21-350	36-500	50+o

Registered disability	◦
Unregistered disabilit	y◦
No disability	◦

Please tick appropriately which best describes your Ethnic Origin.	
White European	0
White Other	O
Black African	O
Black Caribbean	O
Black Other	O
Indian	O
Pakistani	O
Chinese	O
Other	0.

How did you hear about the post?

Are you related or do you know any member of DT Care Services.

REHABILITATION OF EX-OFFENDERS ACT 1974

You are advised that you are not entitled to withhold information about convictions, which are regarded as spent under the Act'. This is due to the nature of the work involved renders the post exempt from sec. 4(2) of the Act in accordance with the Rehabilitation of Offenders Act 974(Exceptions) Order 1975.

You are therefore required to give details of all convictions and cautions including 'spent' convictions. Any in formation, which you 'may give, will be strictly confidential and will be considered only in relation to this or a similar position for which you may be considered with DT Care Services.

Have you ever been convicted of a criminal offence? YES/NO

If yes, please give details of all convictions and cautions, including spent convictions and cautions: (please use a separate sheet if necessary)

You are required to comiplete the Disclosure and Barring Service (DBS) Disclosure form. All health professionals registered with Disclosure and Barring Service are subject to this disclosure process in the interests of all parties concerned.

DECLARATION

I declare that: 1

All information given is true in every respect. I have read and understood the Terms

and Conditions and I agree to comply with the current Health and safety at work Act

(ii) I have never been charged with, or convicted of an offence under any legislation

dealing with Residential care or any offence involving dishonesty or violence.

(iii) I have been issued with a staff handbook and informed of the importance of

reading and understanding it.

Signature..... Date.

Disclosureand Barring Service-ENHANCED DISCLOSURE	
Forenames.....	Surname.
I understand that before I can commence	work with DT Care Services, I will need to be in
possession of a DBS Enhanced Disclosur	e.
Signature.	Date...../...../.....

DOCUMENTS NEEDED FOR

REGISTRATION

VALID WORK PERMIT

(Or if Student, College ID and Student Visa,)

BRITISH PASSPORT (or other current Home Office Document authorizing you to work in UK)

NATIONAL INSURANCE(NI)CARD

(Or P45 or P60 or letter confirming you have applied for Ni

PROOF OF ADDRESS

E.g. Driving Licence, Utility Bill, orany formal letter with your name and address

2 CURRENT PASSPORT SIZE PHOTOGRAPHS

Disclosure and Barring Service CERTIFICATE (DBS) you apply with us.

RIGHT TO WORK ENQUIRY AGREEMENT

I agree and give permission for DT Care Services to take appropriate action and contact the appropriate authorities as a part of their effort to validate my right to.work in the UK.

Print Name:

Signature:

Date:

CONFIDENTIALITY AGREEMENT

I agree that during the time I am engaged DT Care Services 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 DT Care Services all such. information, and never use it in other than for the benefit of DT Care Services.

Print name:

Signature:

Date:

DT Care Services DECLARATION

If you provide false or misleading information to support your application, it will disqualify you from being engaged as an employee of DT Care Services.

If it is found that you provided false or misleading information to support your application after or during employment, DT Care Services has the right to terminate your contract. on this basis.

I hereby declare that I understand and complied with the requirements laid down in the application and I agree that the information given on this form maybe used to obtain DBS checks on më from the policy authorities.

Name print:

Signature:

Date:

BANK DETAILS

Name.

Account Name.

Bank Name.

Bank Address.

Account Number.

Sort Code.

Signature. .Date.

INTERVIEW.

DATE: NAME: POSITION:

Q1) How would you care for someone with personal needs:

Q2) How would you assist individual to maintain independence:

Q3) What would you do if a client has bruises/injury?

Q4) if a client is not eating well or not taking his/her medication what would you do?

Q5) what training do you need for this job?

Q6) what can you say about confidentiality:

Q7) If there is a fire in the client's home what will you do?

Q8) What experience are you bringing into this company and what do you like about your job?

A: EMPLOYEE PERSONAL DETAILS			
Surname:		First Name:	
Date of Birth:		JOB POSITION:	
Contracted Hrsl wk		Start Date:	

B: DECLARATION OF SUITABILITY			
Question	NO	YES	
		Dates	Details
Have you ever had a Criminal Records Bureau check that suggests that you are unsuitable to work with vulnerable nersons?			
Have you ever been disqualified or prevented from being a Care Service Provider?			
Have you ever been disqualified from any registration involved, either directly or indirectly, in the provision of a Care Service?			
Have you ever been involved as owner or manager of a Domiciliary Care Service whose registration was refused or cancelled?			
Have you ever had a financial interest in a Domiciliary Care Service whose registration was refused or cancelled?			
Have you ever been referred to the Vulnerable Adults List, Children's Barred List, or previous lists (SOCA etc)?			
Have you ever had registration as a Care Service Provider refused or cancelled?			

I confirm that the answers to these questions are true and accurate to the best of my belief and knowledge.

I also understand that it is my responsibility to declare any offences or orders which may affect my continued suitability to

care for vulnerable persons.

Signature: Full Name (PRINT):

Date:

WORKING TIME REGULATIONS,1998 EMPLOYEE OPT-OUT AGREEMENT

A: EMPLOYEE DETAILS	
Name of Employee:	
Job Position held:	

B:OPT-OUT AGREEMENT

1,

am aware of The Working Time Regulations,1998, and understand their implications with reference to my Terms & Conditions of Employment.

The Organisation's Staff Time-keeping Records will confirm my hours worked on a weekly basis.Where these records confirm that I have worked in excess of 48 hours per week I agree that this 48-hour week limit under The Working Time Regulations, 1998, shall not apply to me.

I understand that I may agree to opt back into the 48-hour week limit at any time, giving the appropriate notice due.

C: SIGNATORIES

Employee Date	Supervisor/Manager Date

JOB DESCRIPTION-DOMICILIARY CARE WORKER

Policy 152

JOB TITLE: Domiciliary Care Worker

ACCOUNTABLE TO: Domiciliary Care Services Manager/Supervisor

RESPONSIBILITIES:

1. To provide a Service of Care to clients to enable them to lead as independent a lifestyle as possible. This Care Service will involve a programme of personal care and household management that is personalised for each client in the form of a Care Plan.Care duties will therefore include assisting the client with the following activities and in so doing will at all times observe and respect the client's dignity, privacy and independence as far as practical:

1.1 Personal Care:

1.1.1 Dressing and undressing/preparing the client for Day Care or trips out.

1.1.2 Washing/bathing/showering/shaving/grooming/cleaning teeth.

1.1.3 Hair care(washing/brushing).

1.1.4 Nail care (fingernails only).

1.1.5 Toileting and all aspects of personal hygiene.

1.1.6 Continence management.

1.1.7 Care of pressure sores (under appropriate nursing supervision).

1.1.8 Getting in and out of bed.

1.1.9 Assisting with the use of Aids to Daily Living/Rehabilitation Aids, as required.

1.1.10 Helping with rehabilitation programmes, as prescribed by healthcare professionals.

1111 Daylevoning/night sitting services, 2s required.

1.2 Healthcare-assisting the client to take prescribed medication.

1.3 Dietary Care:

1.3.1 Preparation of snacks and meals according to the client's likes/ dislikes. 1.3.2 Assisting with feeding, as required.

1.4 Domestic/Household Services:

1.4.1 General cleaning duties, to include cleaning/dusting/vacuuming/polishing.

1.4.2 Bed-making.

1.4.3 Clearing refuse and rubbish.

1.4.4 Laundering/Handwashing/Ironing/Light needlework, as required.

1.4.5 Fuel Management.

1.4.6 Shopping, and the preparation of shopping lists and assistance with budgeting.

1.4.7 Light gardening tasks (subject to previous agreement at the Care Plan stage).

1.5

Personal services:

1.5.1 Assistance with personal Finances, to include payingbills, collecting pensions.

1.5.2 Personal Planning (birthdays/anniversaries etc)

1.5.3 Democratic rights (voting cards etc).

2. To conform to all Policies and Procedures laid down by the Organisation in respect of carrying out these Care Duties and in other administrative aspects of the business, as relevant.

3. To participate as directed by the Domiciliary Care Services Manager/ Supervisor in Induction Training and regular In service Training programmes.

JOB DESCRIPTION-DOMICILIARY CARE WORKER Policy 152(continued)

4. To maintain accurate,concise and timely records of client care, diary sheets, time sheets and mileage sheets.

5. To participate in Staff,Team and Quality Management Review Meetings as directed by the Domiciliary Care Services Manager/Supervisor.

6. To report back to the Domiciliary Care Services Manager/Supervisor on any aspect of client care which he/she feels warrants investigation or urgent action.

7. To participate in reviews of clients' Care Plans as required.

8. To be aware of the tasks and activities which must NOT be undertaken as part of care duties, as set out in Policy 101.

For your form to be processed, you will need to provide us with:

Full details of your work experience or CV

Copies of all relevant qualifications

Copies of all relevant training

Two written references from recent/past employees or three-character reference (i.e. Doctor,Teacher,Lawyer,Accountant,religious Leader)

Two forms of identification such as Driving Licence &Passport

Two forms of proof of address such as utility bill & bank statement

If you are not a British national we MUST have a clean copy of your Passport, Visa and working permit

Written confirmation that you are in good health

The more you tell us about yourself, the easier it will be for us to successfully find you the most suitable vacancy.

We check all references thoroughly by telephone.