

**CURATE HOSPITALS
EMPLOYMENT APPLICATION FORM**



Recent Photograph

Post for which you are applying

FULL NAME :

NI NUMBER :

ADDRESS :

TEL NO :

NATIONALITY

MOBILE TEL NO:

Work Permit Required

YES / NO

BIRTH CERTIFICATE NO:

*Please bring originals with you for inspection if invited for interview

PASSPORT NO:

*Please bring originals with you for inspection if invited for interview

EDUCATIONAL QUALIFICATIONS

PROFESSIONAL QUALIFICATIONS

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EMPLOYMENT APPLICATION FORM - PAGE 2

PIN NUMBER & EXPIRY DATE (TRAINED STAFF ONLY)

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ARE YOU A REGISTERED DISABLED PERSON ?

YES / NO

IF YES REGISTERED NUMBER

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DO YOU HOLD A CURRENT DRIVING LICENCE

YES / NO

DO YOU HAVE ANY PENALTY POINTS IF YES

YES / NO

PLEASE GIVE DETAILS

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FULL EMPLOYMENT HISTORY SINCE LEAVING SCHOOL IN REVERSE ORDER (MOST RECENT FIRST)

EMPLOYERS NAME & ADDRESS	POST HELD	GRADE & SALARY	FROM	TO	REASON for LEAVING
*					

*Please continue on reverse if required

Please comment on any gaps in your employment history:-

SUMMARY OF PRESENT POST & RESPONSIBILITIES :

The position you are applying for is exempt from the Rehabilitation of Offenders Act 1974, which means that all convictions, cautions, reprimands and final warnings on your criminal record, even if 'spent' need to be disclosed. You are obliged to now disclose **any** details if at any time you have been arrested, charged with or summonsed for a criminal offence of any nature:-
 Please circle below as applicable;

1. **Warning, caution, reprimand or final warning from the Police/Department of Education and Skills or the Department of Health**
2. **I am not waiting to appear in Court for an offence.**
3. **I do not have any 'spent' convictions.**
4. **I understand that a Criminal Records Bureau check will be made on me as part of the application process for which I shall pay 50% of the fee**

Details of any disclosures you wish to make reference points 1-4

I declare that I am physically and mentally fit to work in a care home.

SIGNED DATED

9/1/08

CURATE HOSPITALS

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How much notice of termination will you be required to give?

Please give names & addresses of 2 previous employers whom we may contact for reference purposes - one must be of your current employer

(1)

(2)

* If you have not had a previous employer please leave this blank for completion at interview

YOU MAY / MAY NOT CONTACT MY PRESENT EMPLOYER FOR REFERENCE PURPOSES (please delete as necessary).

Please give name and address of 1 person whom we may contact for a personal reference

CURATE HOSPITALS
MEDICAL ASSESSMENT

CONFIDENTIAL MEDICAL INFORMATION

**NAME &
ADDRESS OF
YOUR G.P.**

TEL NO :

YOUR WEIGHT

**DATE OF
LAST X-RAY**

YOUR HEIGHT

**ANY KNOWN
ALLERGIES ?**

**ANY HISTORY
OF HEPATITIS ?
B,C and A**

Date of last vaccination or blood test

YES \ NO

ANY HISTORY OF HIV, AIDS or TETANUS

**HEARING
(ANY DEFECT)**

**COLOUR
BLINDNESS ?**

EYE SIGHT - DO YOU WEAR SPECTACLES?

YES/NO

**ARE YOU REGISTERED
DISABLED**

YES/NO

**DO YOU HAVE
DIABETES?**

YES/NO

**DO YOU TAKE MEDICATION FOR CONTROL OF ANY
PROBLEMS WITH BLOOD PRESSURE / PULSE OR
TEMPERATURE ?**

YES/NO

DO YOU HAVE A HISTORY OF DEPRESSION? IF SO PLEASE GIVE DETAILS

DO YOU HAVE CARDIOVASCULAR DISEASE? IF SO PLEASE GIVE DETAILS

CURATE HOSPITALS
MEDICAL ASSESSMENT

Do you suffer from epilepsy? If so please give details
Any history of fractures? If so please give details
Any history of arms/legs/neck/back complaints or injuries? If so please give details
Current Medication if any:-
Declaration I declare that the foregoing is a true and accurate statement concerning my state of health and that there are no illnesses, disabilities or conditions not mentioned above from which I suffered or are currently suffering.
Signed Dated

NIGHT WORKERS HEALTH ASSESSMENT

The Working time Regulations 1998 require employers to make available to all employees working or due to work at night a free Health Assessment.

The purpose of this questionnaire is to assess your fitness to work to which you have been assigned. You do not need to complete it if you do not wish to do so but should still sign the Declaration.

You may be referred to a health care professional for further assessment to determine your fitness for night work, depending on the responses.

NAME:	DATE OF BIRTH:	JOB TITLE:
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Do you suffer from any of the following conditions that could be made worse by working at night?

Diabetes, requiring insulin injections to a strict timetable?	YES / NO
A heart or circulatory disorder which affects your physical stamina?	YES / NO
Stomach or intestinal disorder e.g. Ulcers?	YES / NO
Any other condition which makes the timing of meals of particular importance?	YES / NO
A medical condition affecting sleep?	YES / NO
a chronic chest condition?	YES / NO
Any medical condition requiring medication on a strict timetable?	YES / NO
Any other medical condition in which the symptoms get worse at night?	YES / NO

Please give further details of any questions answered 'YES'

will give the employer the right to reject my application or to withdraw any employment contract offered or, if employed, to dismiss without notice.

2. I hereby give my authority for the organisation to contact my own General practitioner for any further details regarding any of the above.
3. I agree that the organisation reserve the right to require me to undergo a medical examination.
4. I do not wish to complete the health assessment.
5. I understand that I am not allowed to sleep at any time during a shift and that failure to comply may result in disciplinary action being taken.

Signed Date

Manager to complete

Further medical necessary / letter to GP	YES / NO	Managers Signature
No further action required	YES / NO	