



OB CARE
HEALTH SERVICE

Job Application Form

Please write in **BLOCK CAPITALS** and in black ink.

POSITION APPLIED FOR:

PERSONAL DETAILS	
Title:	Date of birth:
Forename:	Surname:
Previous Surname:	
Date of use from:	Until:
Gender: FEMALE	Marital status:
NI Number:	
ADDRESS:	
Post code:	

WAYS TO CONTACT YOU:	
Mobile Number:	Home Number:
Email:	

EMERGENCY CONTACT:	
Next of Kin:	
Name:	
Relationship:	Phone:
Address:	
Email:	

WORK HISTORY

Please ensure you complete this section even if you have a CV. Please ensure that you leave no gaps unaccounted for and it covers 10 years.

ABOUT YOUR CURRENT JOB	
Job Title:	Current Pay p/h: £
Duties:	
Current Place of Work:	Day/Night Shift:

Previous Job From:		To:		Name of Employer:	
Job Title:					
Address:				Main Responsibilities:	
Reason for Leaving:					

From:		To:		Name of Employer:	
Job Title:					
Address:				Main Responsibilities:	
Reason for Leaving:					

From:		To:		Name of Employer:	
Job Title:					
Address:				Main Responsibilities:	
Reason for Leaving:					

From:		To:		Name of Employer:	
Job Title:					
Address:				Main Responsibilities:	
Reason for Leaving:					

YOUR EDUCATION, QUALIFICATIONS AND TRAINING

Please ensure you list all educational and relevant training undertaken

EDUCATION				
Establishment:	From:	To:	Qualification	Grade

MANDATORY TRAINING							
<i>Please tick if you have completed the following training within the last 12 months, please enclose copies of your training certificates</i>							
Moving and Handling:	<input type="checkbox"/>	Basic Life Support:	<input type="checkbox"/>	Intermediate Life Support:	<input type="checkbox"/>	Advanced Life Support:	<input type="checkbox"/>
Complaints Handling:	<input type="checkbox"/>	Handling Violence and Aggression:	<input type="checkbox"/>	Fire Safety:	<input type="checkbox"/>	COSHH:	<input type="checkbox"/>
RIDDOR:	<input type="checkbox"/>	Caldicott Protocols:	<input type="checkbox"/>	Data Protection:	<input type="checkbox"/>	Infection Control:	<input type="checkbox"/>
Lone Worker Training:	<input type="checkbox"/>	Food Hygiene (where required to handle food):	<input type="checkbox"/>	Personal Safety (Mental Health & Learning Dis'):	<input type="checkbox"/>	Covid-19	<input type="checkbox"/>
Other:							

PROFESSIONAL MEMBERSHIPS

Please enclose, with your application a copy of your registration and membership card

Professional Body/Type		Pin:	
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Current DBS Disclosure (formally known as CRB):	Yes <input type="checkbox"/> No <input type="checkbox"/>	Clear:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Issue Date:		Disclosure Number:	
Is this certificate registered with the update service?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
<i>You will be requested to carry out a DBS at registration and annually upon employment</i>			

BANK PAYMENT DETAILS

Name of Bank/Building Society:			
Account Name:		Personal <input type="checkbox"/> Or LTD <input type="checkbox"/>	
Branch Address:			
Post Code:			
Account No:		Sort Code:	

DRIVING DETAILS

Do you hold a valid UK driver's licence?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have use of a car?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

IMMUNISATIONS

Please indicate which off the following Immunisations you have been vaccinated against and include your vaccination reports when returning your registration.

EPP and Non EPP	Hep B	TB	Varicella	Measles	Rubella
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
EPP Candidates Only	Hep C	Hep B Antigen		HIV	
	No Proof <input type="checkbox"/>	No Proof <input type="checkbox"/>		No Proof <input type="checkbox"/>	
	Negative <input type="checkbox"/> Positive <input type="checkbox"/>	Negative <input type="checkbox"/> Positive <input type="checkbox"/>		Negative <input type="checkbox"/> Positive <input type="checkbox"/>	

All applications who cannot provide a registered DBS or full immunisation record will be required to complete at their own cost.
Candidates will be required to purchase uniform if required at the cost of £20 this will be deducted from your timesheet once you have started working through us

Please sign to say you have read and understood the above

Your Signature:		Date:	
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REGISTRATION DECLARATION FORMS

Please read before signing

HEALTH DECLARATIONS

We would ask all OVERSEAS candidates to provide a medical statement from their GP or medical department confirming your state of health. Your details will be passed to our Occupational Health Doctors to establish your fitness for work. Please sign the declaration below to allow Obicare Group Ltd. to release your information for inspection.

I consent to Obicare Group Ltd. releasing my health and immunisation records for review. I understand that based on this review I may be required to undergo a medical examination to establish my fitness for work.

I confirm that I will immediately inform Obicare Group Ltd. in confidence if I am HIV Positive, Hep B positive or if I have AIDS in accordance with the Department of Health guidelines. I am aware of my obligations regarding MRSA contact and the need for screening. I agree to immediately inform Obicare Group Ltd. should my general condition of health change.

I will inform Obicare Group Ltd. immediately if I discover that I am pregnant. I understand that withholding information or giving false answers may lead to dismissal. I also hereby consent to Mabeline Services Ltd. obtaining further information regarding my health from my GP or Occupational Health Department.

Signed:		Print Name:		Date:	
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DISABILITY DISCRIMINATION ACT

Applicants with disabilities will be invited for interview if the essential job criteria are met. Do you consider yourself to be a person with a disability as described by the disability discrimination act 1995? i.e. do you consider yourself to be someone who has a physical or mental impairment which has a substantial and long-term adverse effect on your ability to carry out normal day to day activities

Yes No

Signed:		Print Name:		Date:	
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CONFIDENTIALITY

I hereby declare that at no time will I divulge to any person, nor use for my own or any other person's benefit, any confidential information in relation to Obicare Group Ltd. or in relation to any of their employees, business affairs, transactions, or finances which I may acquire during the term of my agreement with Obicare Group Ltd. under the Terms of Engagement.

Signed:		Print Name:		Date:	
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PERSONAL DECLARATIONS

I hereby confirm that the information provided on my application is correct and true to the best of my knowledge and that I have not withheld any information that should be considered when offering me work.

I understand that providing false or inaccurate information may result in the termination of any placement. I agree that I will make best endeavours to make myself aware of the Health & Safety procedures for each client I am assigned to.

I confirm that I have read and understood the Terms of Engagement and the terms of the declaration and agree to be bound by them.

Signed:		Print Name:		Date:	
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WORKING TIME REGULATIONS DECLARATIONS

For the purposes of the Working Time Regulations 1998 (as amended) I, consent to work more than an average of 48 hours per week, averaged over 17 weeks. I understand that I may withdraw this consent by giving Mabeline Services Ltd. not less than three months' notice at any time.

Signed:		Print Name:		Date:	
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OTHER DECLARATIONS

In addition, I also consent to work more than the maximum number of hours permitted to work at night under the directive. Please note you are under no obligation to sign either declaration.

Signed:		Print Name:		Date:	
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HEALTH AND SAFETY

Each agency worker has a responsibility at the start of their first shift to become familiar with the Client's general policies including, without limitation, those relating to Crash Call Procedures, the Hot Spot Mechanism for alerting security staff that an individual is in trouble, Fire Policy and the Violent Episode Policy.

Signed:		Print Name:		Date:	
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RIGHT TO WORK IN THE UK

Please complete this form, regardless of your nationality, as it is a legal requirement. If you are an overseas national or require a work permit to work in the UK, please include copies of supporting documentation.
Your entitlement for working in the UK is based upon what status:

EU Citizen (Visa):	<input type="checkbox"/>	Spouse of an EU Citizen (Visa):	<input type="checkbox"/>	Work Permit:	
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Permit-free Visa:	<input type="checkbox"/>	Right of Abode in the UK:	<input type="checkbox"/>	Admitted to UK as Doctor Prior to 1985:	<input type="checkbox"/>
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REHABILITATION OF OFFENDERS ACT 1974 – Please answer all five questions

Because of the nature of the work for which you are applying, Section 4(2), and further Orders made by the Secretary of State under the provision of this section of the Rehabilitation of Offenders Act (1974) (Exceptions) Order 1975 apply. Applicants are therefore required to give information about convictions which for other purposes are “spent” under the provisions of the Act. Any information given will be completely confidential and will be considered only in relation for positions to which the order applies.

1. Do you have any convictions, cautions or bind overs? If yes please give details...	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you ever had disciplinary action taken against you? If yes please give details...	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Are you at present the subject of criminal charges or disciplinary action? If yes please give details...	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Do you consent to Day Webster requesting a police check and any appropriate references on your behalf?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you been police checked in the last three years? If so, by whom...	Yes <input type="checkbox"/> No <input type="checkbox"/>

Signed:		Print Name:		Date:	
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REFERENCE

Give details of the names/addresses of two work-related Referees. One of the Referees should be your current employer, or if presently unemployed or self-employed, your last employer

1.Name		2. Name	
Position		Position	
Company Name and Address	Post Code:	Company Name and Address	Post Code:
Telephone number		Telephone number	
Email Address		Email Address	
May we contact the above person now?	Yes No <input type="checkbox"/> Please as appropriate <input type="checkbox"/>	May we contact the above person now?	Yes, No <input type="checkbox"/> Please as appropriate

	FOR OFFICE USE ONLY	
Application received date	Interview date	Outcome

Availability

Please specify the kind of Care work are you interested in? (tick all that apply)

NHS * PRIVATE HOSPITAL NURSING HOME * RESIDENTIAL HOME *

OTHER: _____

(Please specify) SHORT TERM LONG TERM *

Please indicate when you would like to work. Please tick all relevant boxes.

PART-TIME * FULL-TIME BANK HOLIDAYS *

DAYS (M-F) * EVENINGS (M-F) NIGHTS (M-F) *

DAYS (SAT-SUN) * EVENINGS (SAT-SUN) NIGHTS (SAT-SUN) EVENINGS (M-F) *

OTHER (Please specify): _____

AVAILABILITY:

When can you start to work: IMMEDIATELY Attend an interview:
IMMEDIATELY

Do you have any holiday booked? Yes No * If Yes, please provide the dates: _____

REGISTRATION CHECKLIST

To complete your registration, you will be required to provide the following documentation

- Completed Registration Form – signed in all requested areas
- Completed Health Questionnaire
- CV – E-mailed in word format
- Your Right to work in the UK as well as your passport, we need a copy of the photo page and the outside of the passport.
- Birth Certificate and Driving Licence
- (For Nurses): HPC or NMC Entry Certificate and up to date renewal card
- Copy of your most recent DBS – less than 1 year old
- Training Qualifications – Diploma/Degree/NVQ – Any other training Certificates
- Mandatory Training Certificates > 1 Year
 - Manual Handling
 - Basic Life Support, Paediatrics need Pead’s Life support and Midwives Newborn Life Support Data Protection, Complaints Handling, COSHH, Fire, Infection Control, Lone worker, Riddor, Violence and Aggression, Health & Safety, SafeguardingChildren & Young People Level 2 minimum (if you need to update these please let us know and we will arrange this for you) · Mental Health Nurses will need Restraint Training
- Immunisations
 - Hep B
 - Varicella
 - Evidence of BCG – OR completed TB form, or confirmation on Letter Head paper, including your details and the GMC NMC number of the practitioner confirming the scar
 - Measles · Rubella
- EPP Candidates (IVS = identification was shown at time of blood test)
 - Hep B Surface Antigen (IVS)
 - Hep C (IVS) · HIV (IVS)
- 2x Passport Size Photos
- Proof of National Insurance Number
- 2x Reference forms. Please ask 2 senior members of staff to complete the reference forms and return them to us.
This is to speed up your application. If we apply for them ourselves, we often struggle to get them returned and it delays the process. We are happy to apply for them if it is not possible for you to get them. Please ensure they include verification. We will contact the referee to verify once they have been received. All references will be verified by a member of the compliance team, via phone or e-mail.
- To be paid through a Limited Company please ensure you send
 - Certificate of Incorporation
 - Evidence of limited bank details and company name ie bank statement or blank cheque
 - VAT Certificate
 - Signed Self Billing Form (enclosed)

THANK YOU FOR COMPLETING THE REGISTRATION FORM

- ✓ Book an appointment to register in the office, if you bring all your documents, we will pay your travel ✓ Get yourself compliant within two weeks and we will give you a FREE uniform
- ✓ We run a weekly payroll service.
- ✓ Do you know if you refer your friends, we will pay you £50 per person? Many of our candidates are earning
- ✓ 100's through referrals every month, why not start today?"

Referral 1. Name:		Telephone Number:	
Referral 2. Name:		Telephone Number:	
Referral 3. Name:		Telephone Number:	
Referral 4. Name:		Telephone Number:	
Referral 5. Name:		Telephone Number:	

You must be fully compliant within two weeks of receiving your registration pack to receive a free uniform. We will pay you £50 for every worker you refer; they must complete 100 hours to receive payment and must be new referrals that are not already held in our data base.

Please send your completed registration pack to:

2nd Floor College House, 17 King Edwards Rd, Ruislip HA4 7AE, UK

Or email: info@obcareservices.com