APPLICATION FORM

POSITION APPLIED FOR: **CARE WORKER**

Return this form to: info@pronashehealthcare.com

PERSONAL INFORMATION Please note: Your name should be in full, as appearing on the NMC register and passport		
Title: MISS	First Name:	Surname:
DOB:	Home Tel No:	Mobile No:
Address:		
Post Code:	City:	
Email Address:		
National Insurance Number:		

NEXT OF KIN	
Full Name:	Relationship:
Address:	
Telephone No:	

GP DETAILS	
Name of Surgery:	
Name of GP:	Tel:
Address:	Post code:

RIGHT TO WORK IN THE UK

I Confirm I am eligible to work In the UK on the following basis:

Are you an EEA National/ Citizen? YES ☐ NO ☐ (please answer next question)

What type of Visa/ Documentation do you hold to support your eligibility to work in the UK?

CURRENT DRIVING LICENCE

YES ☐ **NO** ☐

EMPLOYMENT/EDUCATION HISTORY

Please submit your full Employment/Education history via a copy of your current CV.

- Please supply details of your work history from school to date
- Please explain any gaps of 2 weeks or more

REHABILITATION OF OFFENDERS ACT

Have you been convicted of a criminal offence, been bound over or cautioned or are you currently the subject of any police investigations, which might lead to a conviction, an order binding you over or a caution in the UK or any other country?

Yes ☐ No ☐

If yes, please provide outline on a separate sheet the criminal offence, order binding you over, a caution, including approximate date, the offence and the authority and country which dealt with the offence.

DISCLOSURE AND BARRING SERVICE

All public and private organisations request that an Enhanced Disclosure be obtained for all healthcare personnel acquired from the Disclosure and Barring Service or Disclosure Scotland through Pronashe Healthcare Care Ltd

Do you have an Enhanced Disclosure and Barring Service certificate: Yes ☐ No ☐

Certificate Number: Issue Date: Update service: Yes ☐ No ☐

PROFESSIONAL REFERENCES

Please provide names and contact details of professional referees from your most recent employment, which must cover the last 5 years of employment/education. Referees must be working in senior position to yourself.

REFERENCE 1	
Name:	
	Telephone number:
Organisation name and address:	
Relationship: Consultant	Dates of Employment:

REFERENCE 2	
Name:	Position:
Email Address:	Telephone number:
Organisation name and address:	
Relationship:	Dates of Employment:

GDPR DECLARATION

In accordance with the new general data protection regulations (GDPR) we are asking you to sign this to provide consent for Pronashe Health Care Ltd to collect and retain your information on our system.

Agreement to use my data

I hereby freely give my employer Pronashe Healthcare Ltd consent to use and process my personal data relating to my employment.

In giving my consent:

- **I understand that I can ask to see this data to check its accuracy at any time via a subject access request.**
- **I understand that I can ask for a copy of the personal data held about me at any time, and that this request is free of charge**
- **I understand that I can request that data that is no longer required to be held can be removed from my file and destroyed.**
- **I understand that if I leave my employment, all physical and electronic records will be retained for a period of 6 years after my last contact with Pronashe Health Care.**
- **I understand that you are the Data Controller for my employment, and I can contact you directly if I have any questions or concerns about my data.**

I understand that if I am dissatisfied with how you use my data, I can make a complaint to the government body in charge (Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF or online at www.ICO.org.uk)

Name:	Signature:	Date: 0

DECLARATIONS

Working Time Directive

The Working Time Regulations 1998 require Pronashe Health Care Ltd to limit your average weekly working time to 40 hours.

I can confirm that I have read this document fully and that all the information provided to Pronashe Health Care is correct and to the best of my knowledge and belief.
I give consent to contact referees regarding the information I have provided unless specified otherwise.
I will inform Pronashe Health Care should anything change, that might affect my position and I understand the information given on this form will be processed by computer and used for registration purposes, under the Data Protection Act 1998.

1. I understand that if I am at any stage charged or cautioned after signing this declaration, I must inform Pronashe Healthcare Care.

3. I am not aware of any condition, medical or otherwise, which would affect or limit my employment or performance, other than those declared.

4. I acknowledge and confirm that Pronashe Health Care is authorised to apply for and obtain a Disclosure and Barring Service (DBS) check and references from any previous employers and educational establishments.

5. I declare that the information given herein is true and complete and is not presented in a way intended to mislead. I agree that if I have given false or misleading information or omit to give relevant information now or in the future that Pronashe Health Care may withdraw or terminate my employment.

6. Should Pronashe Healthcare Care require further information and wish to contact my doctor with a view to obtain medical report, the law requires Pronashe Health Care to inform me of their intention and obtain my permission prior to contacting my doctor. I agree that the organisation reserves the right to require me to undergo a medical examination.

7. I acknowledge that my personal details will be stored and handled correctly by Pronashe Healthcare Care in accordance with the Data Protection Act 1998, however, I agree that they may be made available for audit/review by relevant third parties. (This is relevant for all information including all documents - DBS, References).

8. I understand that if I am on a student visa, I can only work for 20 hours per week during term time. I understand that I have a responsibility to monitor this. In addition, if my position as a student changes, I must inform Pronashe Healthcare Care.

9. I understand that if I am on a Tier 2 Sponsorship Visa, I can only work for a maximum of 20 hours per week at the same professional level as my sponsorship. I understand that I have a responsibility to monitor this. In addition, if my position with my sponsored company changes, I must inform Pronashe Healthcare Care Ltd.

10. I acknowledge that if any of my details stated on this Application Form change, or my circumstances change, which may affect my ability to work for Pronashe Health Care, I must inform the organisation immediately.

11. I confirm that I am not currently under investigation, or currently suspended or being investigated by my current or previous employer. I will inform Pronashe Health Care if I am under investigation or suspended at any point while working for Pronashe Health Care Ltd

12. I confirm that when asked about my working history, I will provide accurate information.

13.I acknowledge that I will read through Pronashe Health Care candidate handbook. I will abide and comply with all policies and procedures stated.

Name:	
Signature	**Date:**