

DELIGHT SUPPORTED LIVING JOB APPLICATION FORM

GUIDELINES

- Please complete this application form accurately, giving as much details as possible of your skills and experience relating to this job application.
- Short listing will be based on the information gathered from the form, read in conjunction with the person specification.
- Please ensure the finished form is printed out, signed, dated and returned by the closing date to the address given at the end of this form. We are unable to accept forms returned as email attachments without a signature.
- Please either type directly in this form or print out and complete the form in **black ink** and **BLOCK CAPITALS**.
- Applicants will be treated in the same way whether they are external or internal candidates. Internal candidates should advise their manager that they have applied for another position.

Post Applied for:				
Where did you see this post advertised? Job Centre Plus Newspaper From a friend/family/etc On our website www.delightsupportedliving.co.uk Online (Gumtree, etc) Other (please state)				
Are you looking for: Full time employment Part time employment Live-in				
What days/hours would you be available to work?				



1. PERSONAL DETAILS

Title (MRS, MISS, M	R, DR, or other title	Date of Birth DD/MM/YYY		
Name				
Nationality		National Insurance Number	_	
Address			Home phone	
			Mobile phone	
			Email	
Postcode				
Do you hold a curre	ent driving license?	Yes	Are you willing to Yes	_
	J	No	travel? No	
What form of	Car			
transport do you	Walk			
use? Tick where	Bus			
appropriate.	Cycle			
	Other (state)			

	anything concerning your medical history or state of health that you thin nt to this application? Tick where appropriate.
Yes No	

How much notice are you required to give your current employer?



2. THIS SECTION IS FOR NURSES ONLY

NMC pin number/Reg. number	NMC/Reg. Expiry date
Type of registration (e.g. RGN, RMN, etc)	
Other professional bodies	

Nurses Clinical Details

Please tick the clinical areas you have expertise in:

A&E	Cardiac	Clinics	Community
Diagnostic Imaging x-ray	Elderly \care	Endoscopy	General Wards
Gynaecology	HDU	Health Visitor	Homecare
ITU	Learning Disabilities	Medical	Mental Health
Midwifery	Neonatal	NICU	Nurse Practioner
Nursing home	Occupational Health	ODP	Oncology
Chemotherapy	Orthopaedics	Paediatric A&E	Paediatrics
Palliative	PICU	Practice Nurse	Prison
Radiology	Recovery	Renal	Dialysis
SCBU	Surgical	Theatre	Triage
Urology	Walk in Centre	Other (please specify)	



3. GENERAL EDUCATION AND QUALIFICATION

Secondary Education

School/College Name	Subjects	Qualification gained/ grades	Date Achieved DD/MM/YYYY

Further Education and Professional Training

University/College/Institute Name	Course & Qualifications obtained	Date Achieved DD/MM/YYYY	Result

Other Relevant Training (Short courses, In-service training, etc)

Training Provider	Title of Course	Date Obtained DD/MM/YYYY	Result



4. PREVIOUS EMPLOYMENT

Explain any gaps in employment. Please start with most recent or current employer, to cover previous 10 years.

Employer	Start Date	Leave Date	Duties	Reason for Leaving

Experience, Skills and Personal Qualities (continue on blank page, if required)

What qualities do you have which make you suitable for this type of work?



5. EMERGENCY CONTACT DETAILS

Name	Relationship to you
Address	Telephone Number
	Home
Postcode	Mobile

References

Please give details of two referees. One must be your present or most recent employer. References will only be taken up for the successful candidate. Testimonials or references from friends and relatives are not acceptable.

Name	Name
Position/Job Title	Position/Job Title
Address	Address
Telephone Number	Telephone Number
May we contact this person prior to the interview? Yes No	May we contact this person prior to the interview? Yes No



6. IMPORTANT INFORMATION

Immigration Regulations & Eligibility to Work

 	I am eligible to work in the UK and do not require a work permit. I am already in possession of a work permit to work in the UK I need to obtain a work permit to work in the UK If other, please specify in the space below	
CRB		
nave not a	Supported Living requires the successful applicant to register with CRB/DBS in already done so. A satisfactory Disclosure check will be completed prior to nent. This check is necessary to ensure that DSL fulfils its legal duties.	they
satisfactor Criminal R conviction	e successful in your application, the offer of employment will be subject to a bry Enhanced Disclosure Report. DSL will make a Disclosure application to Records Bureau / Disclosure Scotland, which will reveal any past criminal ns (spent or unspent). Any non-conviction information held locally by the police be disclosed should this be considered relevant to the position.	ce
Do you ha	nave any criminal convictions? Yes 🗆 No 🗆	
•	ease give details on a separate sheet. This should include any spent convicting ection 4(2) of the Rehabilitation of Offenders Act 1974	ons
not work o	lity: Please put the hours that you are available for work each week. Delight on a flexible hour's basis. When thinking about this please take into consider	atior

other commitments. E.g. Child care during school holidays etc. All support workers must work alternate weekends. (This section must be completed)

Hours: From -To -



convictions that I have.

7. DECLARATION BY APPLICANT

I confirm that the information contained in this application is correct, and that all the relevant information has been given. I agree that I am of good integrity and character and am physically and mentally fit to perform the work that the agency will provide me. I am fully aware that I will be required to undertake a Criminal Records Bureau Check to assess my suitability for the post. I understand that if any of the information provided on this application is later found to be incorrect, my employment may be terminated.

Print Name:	 	 	
Signature: Date:	 	 	

I have read and understood the above statement and have disclosed any criminal

By signing and returning this application form, you consent to DSL using and keeping information about you provided by you – or third parties such as referees – relating to your application or future employment. This information will be used solely in the recruitment process and will be retained for six months from the date on which you are informed whether you have been invited to interview, or six months from the date of interview. Such information may include details relating to ethnic monitoring and disability: these will be used solely for internal monitoring.

For Office Use Only

Interview Date	Accept?	Start date	Leave Date	ID, UNIFORM Returned?



HEALTH DECLARATION FORM

Private and Confidential

Date of Birth (DD/MM/YYYY)				
Mobile number				
Wobile Hulliber				
tion				
Telephone: Occupational Health Department:				

To enable us to carry out a health and safety risk assessment to ensure that you are given appropriate work and that you get the right support you need, please tick the appropriate YES/NO box. If the answer to any question is YES then please give details in the space provided.

Have you ever had in your life, including childhood, any of the following?

DESCRIPTION OFF ILLNESS

- 1. Heart/circulation Illness or Hypertension
- 2. Blood Disorder e.g. Anaemia, Haemophilia
- 3. Eye Disease/Injury or Defect of Eyesight
- 4. Asthma, Hay Fever
- 5. Bronchitis, Pneumonia, Pleurisy
- 6. Tuberculosis
- 7. Diabetes
- 8. Epilepsy, Frequent Fainting Attacks
- 9. Headaches, Migraines
- 10. Psychiatric Treatment
- 11. Dermatitis, Psoriasis, Eczema, Skin Sensitivities
- 12. Chicken Pox (if suffered from during childhood, tick YES)
- 13. Hearing Loss, Frequent Ear Infection

YES NO DETAILS/DATE



14. Hepatitis, Jaundice					
15. Bladder/Kidney Infection					
16. Gynaecological Problems, Painful Periods					
17. Gastric Aiments, Ulcer					
18. Back Pain, Sciatica or Deformities of the Spine					
19. Varicose Veins					
20. Do you have any deformities which affect					
movement?					
21. Are you currently receiving any medication from					
the Doctor?					
22. Have you ever treated at hospital?					
23. Are you registered Disable Person?					
24. Date and Result of last X-ray					
		!	4 4 41		_
Have you ever been vaccinated, immunised or test	ed for/a	gains	t any of the	he follov	ving:
Tuberculosis including BCG	ed for/a	gains	t any or ti	he follov	wing:
	ed for/a	gains	t any of the	he follov	wing:
Tuberculosis including BCG	ed for/a	gains	t any or ti	he follov	wing:
Tuberculosis including BCG Heaf, Mantoux or Time	ed for/a	gains	t any or ti	he follov	wing:
Tuberculosis including BCG Heaf, Mantoux or Time Rubella (German Measles)	ed for/a	gains	t any or ti	he follov	wing:
Tuberculosis including BCG Heaf, Mantoux or Time Rubella (German Measles) Poliomyelitis	ed for/a	gains	t any or ti	he follov	wing:
Tuberculosis including BCG Heaf, Mantoux or Time Rubella (German Measles) Poliomyelitis Hepatitis B	ed for/a	gains	t any or ti	he follow	wing:
Tuberculosis including BCG Heaf, Mantoux or Time Rubella (German Measles) Poliomyelitis Hepatitis B Hepatitis B Antibodies (Date and Result)	ed for/a	gains	t any or ti	he follow	wing:
Tuberculosis including BCG Heaf, Mantoux or Time Rubella (German Measles) Poliomyelitis Hepatitis B Hepatitis B Antibodies (Date and Result) HIV	ed for/a	gains	t any or ti	he follow	wing:
Tuberculosis including BCG Heaf, Mantoux or Time Rubella (German Measles) Poliomyelitis Hepatitis B Hepatitis B Antibodies (Date and Result) HIV Tetanus	ed for/a	gains	t any or ti	he follow	wing: