



APPLICATION & REGISTRATION DOCUMENT CHECKLIST

Please ensure you provide the following documents for completion of your registration and application with Brookeview Care Ltd

- Passport/Birth Certificate/Driver's License *
- Proof of Address (e.g. rent receipt, utility bill)
- Original certificates/diplomas/NVQ Qualification
- Certificates of training received in Domiciliary Care
- 2 passport photographs
- Bank/Building Society details
- CRB Enhanced Disclosure check
- National Insurance card/P45/P60
- Current Curriculum Vitae (CV)

* Only one of these items will be required for the purpose of identification.

Please also bear in mind the following when completing your application form and submitting the items required:

- **Passport Photos:**
Please ensure to write your name at the back of your passport photos)
- **Employment History:**
You must provide a continuous employment history for the past ten years, starting with your current or most recent employer. You must explain any gaps in your employment history; you can annotate the explanation in the 'Duties and Responsibilities Section'.
If you need to continue your employment history on a separate sheet, please request an Employment History Continuation Sheet
- **References:**
Please provide two Professional Referees from your current or most recent employers. These Referees must have worked with you in a senior capacity and they should also be able to attach



their company stamp or logo on the reference letter as well as be able to be contacted in order to verify that they completed the reference letter



PERSONAL DETAILS

PLEASE COMPLETE IN BLOCK CAPITALS ONLY

SURNAME:		TITLE:	FORENAME:
PREFERRED NAME:			
OTHER NAMES BY WHICH YOU ARE KNOWN:			
ADDRESS:		POST CODE:	
TELEPHONE (HOME):		MOBILE:	
EMAIL ADDRESS:			
DATE OF BIRTH:		NATIONAL INSURANCE NUMBER:	
NATIONALITY:			
ARE YOU ELIGIBLE TO WORK IN THE UK: YES <input type="checkbox"/> NO <input type="checkbox"/>			
IF YES, STATE VISA STATUS:			
DATE OF ENTRY INTO THE UK: (DD/MM/YYYY)			

NEXT OF KIN DETAILS

NAME:		RELATIONSHIP:
ADDRESS:	MOBILE:	
	CONTACT #:	

POSITION BEING APPLIED FOR:			
AVAILABILITY:	Full Time <input type="checkbox"/>	Part Time <input type="checkbox"/>	
Mon. <input type="checkbox"/>	From: To	Fri. <input type="checkbox"/>	From: To



Tue. <input type="checkbox"/>	From:	To:	Sat. <input type="checkbox"/>	From:	To:
Wed. <input type="checkbox"/>	From:	To:	Sun. <input type="checkbox"/>	From:	To:
Thurs. <input type="checkbox"/>	From:	To:			
Are you interested and available to do any of the following: LIVE-IN <input type="checkbox"/> SIT-IN <input type="checkbox"/> WAKE IN <input type="checkbox"/> SLEEP IN <input type="checkbox"/>					

EXPERIENCE

Please indicate your areas of experience

- No experience/new to health care
- Incontinence management
- Managing people with terminal illness
- Management of aggression
- Managing people with HIV/AIDS
- Managing people with learning difficulties
- Managing people with people with sensory loss and sensory impairment
- Managing lifting & handling equipment
- Managing people with challenging & anti-social behavior
- Managing people with physical disabilities
- Managing people with depression
- Managing people with mental health problems including dementia
- Managing people with alcohol and drugs misuse



EDUCATION AND TRAINING

Please give details of relevant training courses and /or qualifications that you have completed, starting with the most recent

ORGANISING BODY	COURSE TAKEN	FROM (mm/yyyy)	TO (mm/yyyy)	ATTAINMENT



EMPLOYMENT HISTORY

Please give details of all your previous employment (at least 5 years), starting with the most recent. You must give reasons for any gaps such as unemployment, voluntary work, and leave to raise family etc. (continue on a separate sheet if necessary)

EMPLOYER NAME AND ADDRESS:	DUTIES AND RESPONSIBILITIES:
POSITION HELD:	
DURATION EMPLOYMENT From ^(mm/yyyy) To ^(mm/yyyy)	
REASON FOR LEAVING:	

EMPLOYMENT HISTORY CONTINUED

EMPLOYER NAME AND ADDRESS:	DUTIES AND RESPONSIBILITIES:
POSITION HELD:	
DURATION EMPLOYMENT From ^(mm/yyyy) To ^(mm/yyyy)	
REASON FOR LEAVING:	

EMPLOYER NAME AND ADDRESS:	DUTIES AND RESPONSIBILITIES:
POSITION HELD:	

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DURATION EMPLOYMENT

From^(mm/yyyy)

To^(mm/yyyy)

REASON FOR LEAVING:

EMPLOYER NAME AND ADDRESS:

DUTIES AND RESPONSIBILITIES:

POSITION HELD:

DURATION EMPLOYMENT

From^(mm/yyyy)

To^(mm/yyyy)

REASON FOR LEAVING:

REFERENCES

Please detail **TWO PROFESSIONAL** referees from your current or most recent employment

Reference 1
NAME:

Reference 2
NAME:

POSITION:

POSITION:

ORGANISATION:

ORGANISATION:

ADDRESS:

ADDRESS:

CONTACT NUMBER:

CONTACT NUMBER:

EMAIL ADDRESS:

EMAIL ADDRESS:

BROOKEVIEW CARE LTD

6 Beverley Square Leeds, LS11 6BP

Tel : 0113 873 0672/07377 591131, help@brookeviewcare.co.uk, www.brookeviewcare.co.uk

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BANK OR BUILDING SOCIETY DETAILS

FULL NAME
BANK ACCOUNT DETAILS
NAME OF BANK
BRANCH
ACCOUNT NUMBER
BUILDING SOCIETY DETAILS
NAME OF BUILDING SOCIETY
BRANCH
SORT CODE
ACCOUNT NUMBER
BUILDING SOCIETY ROLL NUMBER

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CONFIDENTIAL HEALTH QUESTIONNAIRE

Please answer all the following questions by ticking the appropriate box. If your answer to any question is yes, please give further details.

All the information given in this form will be treated as confidential and will not be divulged to a third party without your consent.

SECTION A	Have you ever had any of the following?	
1. Eczema, dermatitis or other skin condition	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Discharge or infection of the ears or defects of hearing	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. Eye conditions or injuries or defects of sight	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4. Asthma, hay fever or any other allergic conditions, including sensitivity to antibiotics	YES <input type="checkbox"/>	NO <input type="checkbox"/>
5. Recurrent sore throats or sinusitis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6. Recurrent sore throats or sinusitis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
7. Tuberculosis, bronchitis or pneumonia	YES <input type="checkbox"/>	NO <input type="checkbox"/>
8. Episodes of severe chest pain or breathlessness	YES <input type="checkbox"/>	NO <input type="checkbox"/>
9. Heart disease or high blood pressure	YES <input type="checkbox"/>	NO <input type="checkbox"/>
10. Severe headaches	YES <input type="checkbox"/>	NO <input type="checkbox"/>
11. Fits, blackouts or epilepsy	YES <input type="checkbox"/>	NO <input type="checkbox"/>
12. Gastric or duodenal ulcers or frequent or prolonged indigestion	YES <input type="checkbox"/>	NO <input type="checkbox"/>
13. Hepatitis or jaundice	YES <input type="checkbox"/>	NO <input type="checkbox"/>
14. Prolonged back pain or disc problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>
15. Arthritis or rheumatism	YES <input type="checkbox"/>	NO <input type="checkbox"/>
16. Difficulties in bending or lifting	YES <input type="checkbox"/>	NO <input type="checkbox"/>
17. Kidney or bladder infections	YES <input type="checkbox"/>	NO <input type="checkbox"/>
18. Diabetes	YES <input type="checkbox"/>	NO <input type="checkbox"/>
19. Varicose veins	YES <input type="checkbox"/>	NO <input type="checkbox"/>
20. Depression, mental illness or nervous breakdowns	YES <input type="checkbox"/>	NO <input type="checkbox"/>

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21. Operations	YES <input type="checkbox"/>	NO <input type="checkbox"/>
22. Accidents (at work or elsewhere) requiring admission to hospital	YES <input type="checkbox"/>	NO <input type="checkbox"/>
23. Any other conditions requiring hospital treatment or investigation as an in-patient or out-patient	YES <input type="checkbox"/>	NO <input type="checkbox"/>
24. Absences from work or school due to ill health during the past year	YES <input type="checkbox"/>	NO <input type="checkbox"/>

CONFIDENTIAL HEALTH QUESTIONNAIRE CONTINUED
SECTION B

25. Are you currently taking or receiving any form of medication?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
26. Do you smoke?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
27. Do you drink alcohol?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
28. Are registered disabled or in receipt of a disability allowance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
29. Do you normally wear glasses or contact lenses?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
30. How many days have you lost through sickness in the last year?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

If you have answered YES to any of the questions above, please use the space below to provide further details

NAME AND ADDRESS OF YOUR GP:

TELEPHONE NUMBER:



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HEALTH DECLARATION

I know of no health reason that will affect my ability to undertake the duties required of me in the position for which I am applying. All the answers given on this form are true and correct to the best of my knowledge

Signature:

Print Name:

Date:



EQUAL OPPORTUNITIES POLICY

Brookeview Care Ltd is committed to promoting Equal Opportunities. Our policy is to ensure that job applicants and employees receive equal treatment irrespective of their race, color, gender, age or disablement. By completing all sections of this form, you will help us to monitor the effectiveness of our Equal Opportunities policy. All information will be held in strict confidence.

EQUAL OPPORTUNITIES POLICY – MONITORING CHECKLIST

For the purpose of monitoring our Equal Opportunities policy as stated above, please complete the following:

GENDER

Male Female

NATIONAL/RACIAL ORIGIN

Asian	<input type="checkbox"/>	Black	<input type="checkbox"/>	White	<input type="checkbox"/>
Pakistani	<input type="checkbox"/>	African	<input type="checkbox"/>	British	<input type="checkbox"/>
Bangladeshi	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>	European	<input type="checkbox"/>
Indian	<input type="checkbox"/>	British	<input type="checkbox"/>	Other	<input type="checkbox"/>
Other	<input type="checkbox"/>	European	<input type="checkbox"/>		
		Other	<input type="checkbox"/>		

If you have selected 'Other', please detail

DISABILITY

Do you consider yourself as having a disability that could affect your day-to-day work?

YES NO

If **YES**, please give details



DISCIPLINARY ACTION

Have you ever been subject to any disciplinary action?

YES

NO

If YES, please give details (.

HOME OFFICE CIRCULAR HOC 102/88

ALL APPLICANTS MUST ANSWER ALL QUESTIONS ON THIS FORM. FAILURE TO DO SO WILL INVALIDATE YOUR APPLICATION

In accordance with the above circular, you are required to provide the following information which will be passed on to the police authorities to check the existence and content of any criminal record.

Because of the nature of the work for which you are required, jobs and assignments are exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974 (Exemptions) (Amendments) Order 1986. Applicants are, therefore, not entitled to withhold information about convictions, reprimands or final warnings which, for other purposes, are 'spent' under the provisions of the Act and in the event of employment, any failure to disclose such convictions could result in removal from Brookeview Care Ltd list of employees.

Please note that this information will only be provided to and checked with the police authorities after a recruitment interview has taken place.

Please answer the following questions using BLOCK CAPITALS ONLY:

Have you ever been convicted of a criminal offence, cautioned, sentenced, reprimanded or given a final warning by the police? YES NO

If YES, please give details (use additional sheets if necessary)

FULL NAME:

CURRENT ADDRESS:

I HAVE LIVED AT THE ABOVE ADDRESS SINCE:

PREVIOUS ADDRESS (must cover previous 5 years)

DATE OF BIRTH:

PLACE OF BIRTH:

YOUR MAIDEN NAME:

HEIGHT:

COLOUR OF EYES:

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ANY OTHER IDENTIFYING PARTICULARS:

RIGHT TO WORK ENQUIRY AGREEMENT

I agree and give permission for Brookeview Care Ltd to take appropriate action and contact the appropriate authorities as part of their efforts to validate my Right to Work in the UK.

Signature:

Print Name:

Date:

CONFIDENTIALITY AGREEMENT

I agree that during the time I am engaged by Brookeview Care Ltd 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 Brookeview Care Ltd, all such information, and never use it other than for the benefit of Brookeview Care Ltd

Signature:

Print Name:

Date:

DECLARATION

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

If it is found that you provided false or misleading information to support your application after or during your employment, Brookeview Care Ltd holds the right to terminate your contract on this basis. I hereby declare that I have understood and complied with the requirements laid down in the application and I agree that the information given on this form may be used to obtain DBS check on me from the policy authorities.

Signature:

Print Name:

Date:

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