

Novus Care Application Form

Please ensure the application is completed in black pen and BLOCK CAPITALS

Title Mr Mrs Miss Ms Dr Other

Surname _____

Forename _____

Previous surname names _____

Dates this name was used From (DD/MM/YYYY): _____ Until (DD/MM/YYYY:) _____

Previous forenames _____

Dates this name was used From (DD/MM/YYYY): _____ Until (DD/MM/YYYY:) _____

Gender Male Female

Date of Birth / /

Place of Birth (town & country) _____

Nationality _____

National Insurance Number _____

Home Telephone Number _____

Mobile Telephone Number _____

Email Address _____

Current Address _____

Post Code: _____

Date moved in / /

To be able to apply for a CRB, we need to have details of where you have lived over the last 5 years. Please complete the addresses in full, including full post code and the dates you lived there (continue on a separate piece of paper if necessary).

Previous Address 1:

Post Code:

Dates lived there:

from: / /

until: / /

Previous Address 2:

Post Code:

Dates lived there:

from: / /

until: / /

Previous Address 3:

Post Code:

Dates lived there:

from: / /

until: / /

Do you have a full UK driving licence?

| | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

Do you have your own transport?

Employment History: (please include Employment History covering 10 years. Explain all gaps in employments. Continue on a separate page if necessary)

Current/Most Recent Employment

Position _____

Organisation _____

Address _____

Post Code:

Telephone Number _____

Manager's Name _____

Employment Dates From: _____ Until: _____

Reason for leaving _____

Previous Employment

Position _____

Organisation _____

Address _____

Post Code:

Telephone Number _____

Manager's Name _____

Employment Dates From: _____ Until: _____

Reason for leaving _____

Previous Employment

Position _____

Organisation _____

Address _____

Post Code: _____

Telephone Number _____

Manager's Name _____

Employment Dates From: _____ Until: _____

Reason for leaving _____

Education

Relevant Training/Qualifications/Training

GP Details

Name _____

Address _____

Post Code: _____

Telephone Number _____

Next of Kin Details

Name _____

Address _____

Post Code: _____

Telephone Number _____

Relationship _____

Do you have any criminal convictions (current or spent) or have you been subject to any conditional discharge, warnings or cautions? No Yes

If Yes please supply all details:

Declaration:

I certify that the information I have provided is truthful and accurate, and I understand that giving false information in order to obtain employment will result in the termination of any contract of employment I have been offered

Signed _____

Date _____

Reference Requests

(please supply at least 2 referee's details. This should preferably be 2 work references, but 1 work reference and 1 character may be acceptable. One work reference must be your current or most recent employer)

Current/Most Recent Employment

Organisation _____

Address _____

Post Code:

Telephone Number _____

Referee's Name & Position _____

Work Reference 2

Organisation _____

Address _____

Post Code:

Telephone Number _____

Referee's Name & Position _____

Reference 3 (work or character reference)

Organisation _____

Address _____

Post Code:

Telephone Number _____

Referee's Name & Position _____

(if a character reference, please state the relationship between you and the referee, how long you have known them and it what capacity)

Medical Questionnaire

Do you, or have you ever suffered from:

- | | | |
|--|------------------------------|-----------------------------|
| Back pain/joint pain/pains in your knees | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy, fits, blackouts or fainting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hearing problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Visual problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stress, anxiety or depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stomach/Bowel problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hayfever or Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart complaints | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Reaccuring headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Raised blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Any other medical issue (please state): _____

If yes to any of the above, please supply full details below:

In the past 2 years, how many days off work have you had due to sickness? Please give the reason:

Information provided during this questionnaire will determine whether you are fit to carry out the role you have applied for. All information provided will be kept strictly confidential.

Equal Opportunities

Gender: Male Female

Nationality/Racial Origin:

| ASIAN | BLACK | WHITE |
|--------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Bangladeshi | <input type="checkbox"/> African | <input type="checkbox"/> British |
| <input type="checkbox"/> British | <input type="checkbox"/> British | <input type="checkbox"/> European |
| <input type="checkbox"/> Indian | <input type="checkbox"/> Caribbean | <input type="checkbox"/> Other |
| <input type="checkbox"/> Pakistani | <input type="checkbox"/> European | |
| <input type="checkbox"/> Other | <input type="checkbox"/> Other | |

Religious Belief:

Do you speak any other language: Yes No

if yes, please state:

Disability:

Do you consider yourself to have a disability which will affect your day to day work?

Yes No

if yes, please state:

Sexual Orientation:

| | |
|--------------------------------------|--|
| <input type="checkbox"/> Hetrosexual | <input type="checkbox"/> Transgender |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> Transexual |
| <input type="checkbox"/> Gay | <input type="checkbox"/> Other |
| <input type="checkbox"/> Lesbian | <input type="checkbox"/> Prefer not to say |

Thank you for your information

Availability

Please can you state the days and the hours you are looking to work. Any offer of employment will be based on the availability you state here. Any changes to availability will need to be put in writing with 4 weeks notice and is at the discretion of the manager.

Days: (tick all that apply)

| | AM (6.00am-12.00) | Lunch (12.00-15.00) | PM (15.00-18.00) | Evening (18.00-22.30) |
|-----------|--------------------------|--------------------------|--------------------------|--------------------------|
| Monday | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuesday | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Wednesday | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thursday | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Friday | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Saturday | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sunday | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Nights (20.00-8.00)

Waking Nights

Sleep Ins

Any Comments:

We will need all employee's to committ to working some weekends depending on our business needs

Please state below if this is not something you can consider:
