Trinity Healthcare
Grosvenor House
102 Beverley Road
Hull
HU3 1YA

Telephone:
01482 581581
Facsimile:
01482 581582
Email: info@
trinity-healthcare.co.uk

Please attach three passport size photographs of yourself here

APPLICATION FORM

PERSONAL DETAILS

Surname _____

Forename _____

Title _____

Any Previous Names _____

Home Tel. No. _____

Mobile Tel. No. _____

Are you registered with any other agencies?
Please list

1 _____

2 _____

3 _____

Address _____

_____

_____

Town _____

Postcode _____

Email _____

N.I. Number _____

Are you legally eligible for employment in the UK? YES/NO

Do you require a work permit? YES/NO

Do you hold a current driving licence? YES/NO

Have you access to a motor vehicle? YES/NO

EDUCATION

School/College/Further Education	*Qualifications*	*Year Obtained*

Other information

If you consider yourself as having a disability, is there any support you would require to attend for interview? Please specify (eg, wheelchair, accessible rooms, etc.)

_____

Are you related to any employee of this organisation? Yes/No

Employment and Experience (most recent first)

From	*To*	*Name and address of employer*	*Job title/duties*

Continue on a separate sheet if necessary

Experience

Client group	*Years/months*	*Client group*	*Years/months*
Adolescents		Mental health	
Autism		Palliative care	
Auxiliary/Hospital		Physical disability	
Elderly		Rehabilitation	
Homecare		Respite care	
Homeless		Sensory impairment	
Learning difficulties		Substance Misuse	

Training

Course title	*Complete Yes/No*	*Year*	*Course title*	*Complete Yes/No*	*Year*
Manual/people handling/ hoist training			Health and safety		
Infection control			Restraint training		
Basic life support			Ethical intervention (CPI)		
Food hygiene			NVQ-2/3/4 (delete as appropriate)		
Makaton			Medication		

Any other relevant training courses

Experience, knowledge and skills

Please tell us why you would succeed in this position, giving a brief outline of your experience and skills and how these meet the requirements of the enclosed job specification. You may also provide any other information that you think is relevant to this position. (Continue on a separate sheet if necessary.)

References

Please give the name and address of two referees, one of whom should be your present or most recent employer. Friends and family members are NOT acceptable referees.

Name _____

Title _____

Address _____

_____

_____

Tel: _____

Role/relationship with referee _____

_____

Name _____

Title _____

Address _____

_____

_____

Tel: _____

Role/relationship with referee _____

_____

Rehabilitation of Offenders Act 1974 - Notice to Offenders

Because of the nature of the work involved, the post for which you are applying is exempt from Section 4(2) of the Rehabilitation of Offenders Act 1974 by virtue of the Rehabilitation Offenders Act (Exemption Order 1975). This means that you are not entitled to withhold information relating to any convictions you may have had.

Do you have any convictions to disclose? Yes/No

Any information should be given on a separate sheet and sent with this application form. This information will be treated as confidential and will not necessarily preclude you from employment.

Health Screening

This appointment will be subject to satisfactory completion of the Health Declaration overleaf.

I declare that the information given is correct to the best of my knowledge. I understand that omissions or false statements may disqualify me from employment or lead to dismissal. I give ***Trinity Healthcare*** permission to contact referees or any previous employers.

Signature _____ Date _____

Personal Health Questionnaire

Please identify whether you have or are suffering from the following:

Asthma . . . . . .Yes/No
Back trouble . . . . . .Yes/No
Deafness . . . . . .Yes/No
Diabetes . . . . . Yes/No
Eye Trouble . . . . . .Yes/No
Fainting attacks . . . . . .Yes/No
Fits or Blackouts . . . . . .Yes/No
Heart Trouble . . . . . .Yes/No
High Blood Pressure . . . . . Yes/No
Mental Illness . . . . . Yes/No
Muscle/Joint trouble . . . . . Yes/No
Recurring Bowel trouble . . . . . Yes/No
Recurring Chest Disease . . . . . Yes/No
Recurring Headaches . . . . . Yes/No
Stomach trouble . . . . . Yes/No

Have you any disability which may affect your ability to stand, walk, climb stairs, lift, use hands or drive? Yes/No

Are you currently seeing a doctor about a specific problem? .. . . . . Yes/No

If the answer to the question above is Yes, please give details

Are you having any treatments prescribed by a doctor? . . . . . Yes/No

In the last two years have you had any incidences of sickness that have necessitated time off work? . Yes/No

If the answer to the question above is Yes, how many? _____

Are you a smoker? . . . . . Yes/No

At present do you or have you recently suffered from:

Ear, nose or throat troubles . . . . . Yes/No
Skin troubles . . . . . Yes/No
Diarrhoea . . . . . Yes/No

Inoculations

Type		*If Yes, give date*			
Rubella	Yes/No	_____	Polio	Yes/No	_____
Tetanus	Yes/No	_____	Tuberculosis	Yes/No	_____
Hep B	Yes/No	_____	Varicella	Yes/No	_____

MRSA Disclosure

I confirm that to the best of my knowledge I am clear of MRSA at present.
Should I come into contact or have any suspicion that I have come into contact with MRSA, I will inform Trinity Healthcare immediately.

I certify that I am in good physical and mental health. I declare that the above information is true and correct to the best of my knowledge and that I have not omitted relevant details. I agree to inform you of any changes in my health and understand that if false statements have been made, then it may result in de-registration.

Signed _____ Date_____