New Dawn Initiative

New Dawn Initiative, is an Equal Opportunities Employer

Attach photograph

APPLICATION FORM

CARE WORKER REGISTRATION FORM

APPLICANT'S DETAILS (Please use black ink) **Title: Mr. /Mrs. /Miss/Ms.** ___________

Surname: ______________________________ **First Names:** ____________________
Marital Status: __________________________
Maiden Name: ____
Address: ____
____ Post Code: _________________

Tel. No. Daytime: __________________________ Evening: _____________________
Date of Birth: ________________ National Insurance No.: _____________________
Nationality: ____________________ Email address: ____________________________

Do you have use of a car for homecare work? YES / NO
Do you hold a full driving licence? YES / NO
Next of kin to be contacted in case of emergency:
Name: ____
Address____
____
Post code: ______________________________ Telephone number_______________
Relationship______________________________ Work contact number _____________

Passport and work permit details

Work Permit YES ☐ NO ☐ Expiry date: ________________
Passport nationality__________________________ Place of issue: _________________
Passport number: __________________ Date of issue: ___________ Expiry date: _________
Known restrictions in use: ____

Preference regarding work:
The service we provide depends on accurate up to date information. Please keep us informed of all developments, in your career and work preferences:
Do you have any other work commitments? YES ☐ NO ☐
Do you work for other company? YES ☐ NO ☐
If yes, please give details: ____
When will you be available to start work? ____
Areas able to cover: ____

PLEASE RETURN THIS FORM TO: admin@newdawninitiative.org

Work experience/Education:

Please start with your present or most recent employer and work back. **You will need to attach your CV or explanation of any GAPS in your employment as we will want to know your full work history.**

Name & address of employer	**Position(s) held; duties performed**	**Date from**	**Date to**	**Reasons for leaving**

Give details of all training undertaken, including short course.

Course Title	From/To	Training Agency

MEDICAL HISTORY:

Are you receiving any medical treatment at present, or do you have a chronic recurring illness?
YES / NO If YES, give details: ____

Have you suffered from any of the following conditions?

Asthma, bronchitis or other chest disorders?
YES / NO
Details: ______________________________
____

Any psychiatric or nervous condition requiring treatment? YES / NO
Details: ______________________________
____

Heart disease or high blood pressure? YES / NO
Details: ______________________________
____

Any skin disease or allergic condition?
YES / NO
Details: ______________________________
____

Epilepsy or fits of any type? YES / NO
Details: ______________________________
____

Back problems of any kind: YES / NO
Details: ______________________________
____

Are you suffering from any illness or disability at present? YES / NO
Details: ____

Are you registered disabled? YES / NO If YES, give registration No. ___________
Details of Disability: ____

Have you suffered any serious illness or injury during the past two years which has resulted in time off work? Please give details: ____

Please state which languages you speak, including an indication of fluency:
____

Do you smoke? YES / NO

'Do you have any convictions, cautions, reprimands or final warnings that are not "protected" as defined by the Rehabilitation of Offenders Act 1974 (Exceptions)
Order 1975 (as amended in 2013) by SI 2013 1198'

NO ☐

YES ☐

Details:

REFEREES

Please give details of two referees (one of whom must be your present employer, or if unemployed, your last employer). **Close relatives or friends are not acceptable as referees.**

1. Name:______________________________
   Company:____________________________
   Address:____________________________
   ____
   Postcode:___________________________
   Tel. No.:___________________________
   Fax. No.:___________________________
   Email address:______________________

2. Name:______________________________
   Company:____________________________
   Address:____________________________
   ____
   Postcode:___________________________
   Tel. No.:___________________________
   Fax. No.:___________________________
   Email address:______________________

Declaration of confidentiality:

Registration implies acceptance of our code of confidentiality.
In the course of your duties, you may have access to confidential information about your clients. On no account must information relating to identifiable clients be divulged to anyone other than your manager or his/her assistant.

You should not disclose any information to your family, friends, or neighbours.

If you are worried by any information you have obtained and consider that you should talk about it to someone else, make an appointment to speak in private to the Manager. In case of abuse, our Abuse Policy takes precedence.
Failure to observe these rules will be regarded as serious misconduct which could result in removal from the agency register

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NB: ALL CARE ASSISTANTS WILL UNDERGO A DISCLOSURE AND BARRING SERVICE (DBS) CHECK BEFORE AN OFFER OF EMPLOYMENT IS MADE.

Please state how you heard of **Waybridge Housing Solutions**.____________________________

DECLARATION OF ACCURACY:

The information I have given in this registration form is, to the best of my knowledge, complete and accurate in all aspects.

I understand that knowingly giving false information will disqualify me from registration with this agency.

Signed: ____ Date: ______________________________

DATA PROTECTION

I CONFIRM THAT I HAVE BEEN INFORMED THAT A WORK STATUS CHECK MAYBE CARRIED OUT AND I HAVE GIVEN PERMISSION FOR MY PERSONAL INFORMATION TO BE SHARED WITH UKBA FOR THESE PURPOSES. I UNDERSTAND THAT MY DETAILS MAY BE HELD BY THE UKBA

NAME:____

DATE: ______________________

SIGNATURE: ______________________________