Registration Pack Check List

We have provided this check list for you to ensure all boxes are marked and supporting documentation provided before returning to Keystone Healthcare Ltd.

(x = no √ = yes)

- Up to date CV ☐
- Eligible to work in the UK (Passport and Work Permit if applicable) ☐
- Passport size photograph in colour (Not required if registering in the office. ☐
- 3 copys of identification- Passport/Driving Licence/Birth Cert/Marriage Cert ☐
- Photocopy of National Insurance Card or Wage Slip ☐
- Photocopy of in date Motor Insurance Certificate ☐
- Professional Reference 1 (Contact Details of Current/Last Employer) ☐
- Professional Reference 2 ☐
- Professional Reference 3 ☐
- Registration Form Completed **(please ensure all sections completed and returned)** ☐

Please note that the cost to return this pack varies on the weight we recommend for you to have this weighed – the estimated cost is 2 first class stamps.

Please read this as this will be important if your application is successful...

If your application is successful we will invite you to our office for an interview. If you attend the interview you will need to bring with you:

- Passport & Driving Licence ☐
- In date Business Motor Insurance certificate ☐
- Utility Bill or Bank Statement ☐
- National Insurance Card ☐
- Complete & up to date CV ☐

All these important documents need to be brought to your interview if you haven't already sent them in with your application pack.

DOMICILIARY CARE /HOME CARE APPLICATION FORM

Please complete all sections using black pen and block capitals

Personal Details

Title: Forenames: Surname:

Name you wish to be known by:

Address:

Post Code:

Telephone Number: Mobile Phone:

Email:

Date of Birth: / / National Insurance Number:

Employment Eligibility (only complete if not a UK citizen)

Birth Certificate Number: Nationality:

Passport Number: Exp Date: / / Home office letter Ref. Exp / /

What is your work status (if not UK Citizen):

Work Permit Held: Yes ☐ No ☐ Type of Work Permit: Exp / /

Transport

Do you hold a current driving licence: Yes ☐ No ☐ Do you have your own transport Yes ☐ No ☐

Do you have valid vehicle insurance to cover business purposes? Yes ☐ No ☐

Application Details

Job Reference of position you are applying for:

Our service operates from 7:00a.m. to 11:00p.m. Monday to Sunday and unless the job advert specifies otherwise, you would be expected to work during these times.
Please give details below of any times when you **would not** be available to work.

Why do you want to work in Domiciliary Care?

What skills/attributes can you bring to the role?

Any additional information which may support your application

Employment History

Present / Last Employer Name and Address

Postcode:

Telephone Number:

Job Title:

Date Started: Date Finished:

Description of Responsibilities:

Reason for Leaving:

Previous Employers	Date Started	Date Finished
You **must** give details of all previous employment **and** explain any gaps between employers.		

Continue on a separate sheet if necessary		

Professional References

Keystone Healthcare requires a reference from your present or most recent employer. By this we mean **actual employers not colleagues.**

Reference 1(Present or most recent employer)

Name of referee: Position:

Company Name:

Mailing Address:

Post Code:

Telephone Number: Fax:

Email Mobile Phone:

Reference 2 (Previous employer)

Name of referee: Position:

Company Name:

Mailing Address:

Post Code:

Telephone Number: Fax:

Email Mobile Phone:

Reference 3 (Previous employer)

Name of referee: Position:

Company Name:

Mailing Address:

Post Code:

Telephone Number: Fax:

Email Mobile Phone:

If you are unable to provide a second/third reference from previous employers, we may accept references from a professional person known to you but not family and friends.

Training and Development

Training and Professional Qualifications

Institution	Address	Qualification	Date

Mandatory Training

	Date Completed	Update Due
Safeguarding Adults		
Food Hygiene		
Moving and Handling		
Health and Safety		
RIDDOR (Reporting of Injuries Deaths and Dangerous Occurrences Regulations 1992)		
COSHH (Control of Substances Hazardous to Health)		
Administration of Medication		
Infection Control		
Fire safety		

Common induction standards

Have you completed Common Induction Standards? ☐ Yes ☐ No

Date of completion: Assessing body:

We require evidence of all training/qualifications – please supply certificates

Declaration of Health

Title:	Surname: (Name should be in full, in print, as appearing on passport)	First Names
Previous Names:		Date of Birth:
Job Title:		
Current Address:		
Permanent Address (if different from above):		
Home Telephone Number:	Work Telephone Number:	Mobile Telephone Number:
Email Address: (Please indicate accurately each character of your email address including full stops, comma etc)		

Information contained within this document is governed by the Data Protection Act 1998. The information is assessed by our Occupational Health provider, who will approve your fitness to practise. The information will be disclosed for the administration of your application and as part of the process in placing you in temporary or permanent work. Only authorised Keystone Healthcare Group employees and their Occupational Health providers will have access to this information until you have confirmed that you wish you details to be sent to a potential employer or third party in order, to find you work. Please ensure the health statement is completed fully and return it to Keystone Healthcare Group as soon as possible.

Medical History

Do you now, or have you ever, suffered from or received treatment for the following? If your answer to any of these questions is YES please give details in the space overleaf, attach additional paper if required	
1. respiratory symptoms, disorders, or diseases? (including asthma, tuberculosis, bronchitis, allergies)	No / Yes
2. skin symptoms, disorders or diseases? (including eczema, dermatitis, allergies)	No / Yes
3. psychological/psychiatric symptoms, disorders or diseases? (including anxiety, depression, stress, alcohol / drugs / substance misuse or dependence anxiety, episodes of disorientation, agitation, episodes of self-harm, violence, aggression)	No / Yes
4. back or neck symptoms, disorders or diseases?	No / Yes
5. impairment or disability of the upper or lower limbs?	No / Yes
6. uncorrected vision problems? (including recurring eye infections, tunnel vision)	No / Yes
7. hearing problems? (including recurring ear infections, hearing deficits)	No / Yes
8. neurological symptoms, disorders or diseases? (including epilepsy, dizzy spells, blackouts)	No / Yes
9. cardiovascular symptoms, disorders, or diseases? (including high blood pressure, angina, blood disorders or diseases)	No / Yes
10. gastrointestinal symptoms, disorders, or diseases? (including diarrhoea, vomiting, Crohns, Irritable Bowel Syndrome, Diverticulitis, food borne diseases)	No / Yes
11. genito-urinary / gynaecological symptoms, disorders or diseases?	No / Yes
12. endocrine disorders or diseases? (including diabetes)	No / Yes

13. immuno-deficiency symptoms, disorders or diseases?	No / Yes
14. communication (speech) problems?	No / Yes
15. any other health problems not mentioned above?	No / Yes
16. Have you ever had any health problems related to your work?	No / Yes
17. Have you ever claimed a disability pension, industrial injury benefit or been refused life insurance or employment on health grounds?	No / Yes
18. Have you ever been an in-patient or out patient at any hospital, clinic, nursing home or accident or emergency department?	No / Yes
19. Are you currently pregnant, breastfeeding or have you given birth in the last 6 months?	No / Yes
20. Are you presently receiving, or awaiting treatment for a physical or mental health problem?	No / Yes
21. Are you currently taking any prescribed or over the counter medications?	No / Yes
22. Have you lived outside UK for a period of longer than 6 months?	No / Yes
23. Have you had chickenpox as a child or adult? If so at what age?	No / Yes
24.How many days sickness absence have you had during the last 2 years? (please give details below)	
Please give additional details here – continue on a separate sheet if required.	

DECLARATION

I confirm that I have read this document fully and that all the information given to Keystone Healthcare Group is correct to the best of my knowledge and belief.
I am aware of the need to protect patients and myself and agree to notify Keystone Healthcare Group should my circumstances alter.
I am aware that where I have provided false information as part of this assessment process, Keystone Healthcare Group reserves the right to report this to my employer / placement supervisor.
I consent to the release of my fitness for work and immunity status only to prospective employers.

Signature:

Print Name: Date:

Rehabilitation Of Offenders Act

Because of the nature of the work for which you are applying, this work is exempt from the provisions of section 4.2 of the Rehabilitation of Offenders Act 1974 (Exemption Order 1975). Applicants are therefore, not entitled to withhold information about convictions 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 dismissal or disciplinary action. Any information given will be completely confidential and will be considered only in relation to the application for positions in which the Order applies, and should be entered at the end of any particulars you give in support of your application.
A copy of our recruitment and selection policy is available upon request. A criminal record will not necessarily be a bar to obtaining a position. Further guidance can be obtained by reference to the CRB's code of practice, a copy of which is available from our office or on the CRB website www.crb.gov.uk

Have you ever been convicted of a criminal offence? ☐ Yes ☐ No

Have you completed an enhanced CRB? ☐ Yes ☐ No
With an Enhanced Disclosure, under Section 4.2 of the Rehabilitation of Offenders Act 1974 (Exemption Order), all previous cautions, warnings and convictions will always be detailed regardless of how long ago they occurred.

Do you have any spent or unspent criminal convictions? ☐ Yes ☐ No
Any Conviction, caution, reprimand will require a written statement of each and every event and how it does not affect your ability for the role you are applying for.

Have you provided an original Enhanced CRB Disclosure ☐ Yes ☐ No

Disclosure Number:

Have you supplied additional information with this Registration form for any spent/unspent convictions, cautions or reprimands?
☐ Yes ☐ No

Have you ever been involved in court proceedings? ☐ Yes ☐ No

You must complete the new CRB Disclosure form, even if you have one already with your current employer

Marketing Information

How did you hear about Keystone Healthcare?

☐ Job Centre/Job Centre Plus ☐ Newspaper Advert ☐ Yellow pages ☐ Thomson Local

☐ Keystone Employee (please give name)

☐ Other (please state)

Equal Opportunities

Keystone Healthcare adheres to a policy that promotes equal opportunity. To ensure that the policy works effectively please complete the following.

Age: ☐ 16-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55+

Gender: ☐ Male ☐ Female

Gender Identity (Optional): If you identify as a transsexual or transgender or as intersex please indicate which group you identify with. ☐ Transsexual ☐ Transgender ☐ Intersex

Ethnic Origin:

White: ☐ British ☐ Irish ☐ Other White

Asian: ☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Other Asian

Black: ☐ African ☐ Caribbean ☐ Other Black

Mixed: ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Other Mixed

Other: ☐ Chinese ☐ Other Ethnic Groups ☐ Prefer not to say

Do you consider yourself to have a disability?

☐ Yes ☐ No ☐ Prefer not to say

Religion: ☐ Bahia ☐ Buddhist ☐ Christian ☐ Hindu ☐ Jain ☐ Jewish ☐ Muslim ☐ Sikh ☐ Other ☐ Prefer not to say ☐ No Religion

Declaration

PLEASE GIVE ANY ADDITIONAL INFORMATION WHICH YOU MAY THINK MAY BE RELEVANT IN SUPPORT OF YOUR APPLICATION ON A SEPARATE PAGE.

Please tick the boxes below in confirmation.

☐ I confirm that the information I have provided in support of this application is complete and true and understand that knowingly to make a false statement could be a criminal offence.

☐ I consent to Keystone Healthcare checking the details I have provided in support of this application form against the various data sources in order to verify my identity and process this Registration. These details may be recorded and used to assist other organisations for identity verification purposes such as the CRB.

☐ Keystone Healthcare reserves the right to hold this registration form and any other data required to process your registration (whether in the UK, European Union or elsewhere) and keep for as long as necessary in line with the Data Protection Act.

☐ I consent to my personal information being shared as described above and I further consent to my personal file being made available to the Care Quality Commission, Skills for Care (the workforce development organisation for social care) and Local Authority Social Services.

☐ I acknowledge the terms and conditions laid down by Keystone Healthcare and agree to abide by them.

Print Name: Signed: Date: / /

Next of Kin Details

Name: Relationship:

Telephone Number: Mobile Number:

Mailing Address:

Country: Post Code:

Bank Details

Name of Bank/Building Society:

Address:

Account Holder:

Account Number:

Sort Code:

Please note that all information will be kept strictly confidential and is passed onto our Finance team immediately.