HEALTHCARE & SUPPORT WORKERS' REGISTRATION FORM

A. YOUR PERSONAL DETAILS

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (Please State)

Surname: First Name(s):

Address:

Post code:

Daytime Phone Number: Mobile:

E-mail address:

Nationality Do have use of you own car / Drive? Yes ☐ No ☐

Do you hold a current full UK driving license: Yes ☐ No ☐

B. YOUR ELIGIBILITY TO WORK / PASSPORT DETAILS

Eligibility to work in the UK YES ☐ NO ☐

I am eligible to work in the UK and do not require a work permit ☐

I have a work permit to work in the UK ☐ I need a work permit to work in the UK ☐

If other please specify

National Insurance Number: Passport Number:

Work Permit / Visa Number: Work Permit / Visa Expiry:

C. SKILLS CHECKLIST & PROFESSIONAL CONDUCT

Please tick all the areas in which you have experience:

Dementia ☐ Personal Care ☐ Incontinence of Service User ☐ Epilepsy ☐ Use of Hoists ☐

Moving and Handling of Service User ☐ Mental Health ☐ Autistic Spectrum Disorder ☐

Managing Challenging Behaviour ☐ Lone Working ☐ Documentation ☐ Elderly Care ☐

Learning Disability Experience ☐ Supported Living ☐ Stroke ☐ Rehabilitation ☐ Autism ☐

Brain Injury ☐ Other:

D. YOUR EMPLOYMENT & VOLUNTARY EXPERIENCE HISTORY

Please print clearly. Give details of the last 3 years of employment and voluntary experience. If you have worked in Health and Social Care prior to the 3 years, please also include details of this employment. You must state reasons for any breaks in employment. Please start with your most recently held position. Continue on a separate sheet if necessary and enclose a copy of your current CV.

EMPLOYMENT EXPERIENCE

DATE FROM MM/YY	DATE TO MM/YY	EMPLOYER'S NAME AND ADDRESS	POSITION AND PRICIPAL DUTIES	REASON FOR LEAVING

VOLUNTEER EXPERIENCE

TYPE OF VOLUNTEER EXPERIENCE	WHERE / DATES	EXPERIENCE GAINED

E. EDUCATION AND RELEVANT TRAINING

NAME OF SCHOOL / COLLEGE / UNIVERSITY	DATES OF TRAINING / ATTENDANCE	QUALIFICATIONS OBTAINED

RELEVANT POST REGISTRATION / MANDATORY TRAINING

NAME OF COURSE OR STUDY	OBTAINED	EXPIRES	TRAINING PROVIDER

F. DECLARATIONS

PROFESSIONAL CONDUCT

Has there been any proceedings of medical negligence or professional misconduct against you?

☐ Yes ☐ No

Have you ever been suspended or dismissed? ☐ Yes ☐ No

If "Yes" please provide details:

REHABILITATION OF OFFENDERS ACT

The position you are applying for (whether paid or voluntary) is listed in Schedule 1, Part II of the Rehabilitation of Offenders Act (Exceptions) Order 1975, so we are entitled to ask Exempted Questions as defined by Section 113(5) of The Police Act 1997 about you.

The nature of the work placements offered by us means the terms of Section 4 part 2 of the Rehabilitation of Offenders act (1974) (exceptions) Order 1975, apply. You must declare here any convictions or cautions you have ever received, even those which would normally be considered spent.

Have you got any unspent conviction either criminal or civil? YES ☐ NO ☐

If yes, please give details:

G. YOUR NEXT OF KIN / EMERGENCY CONTACT DETAILS

1. Name:

Relationship to you:

Address:

Postcode:

Contact Phone Number:

2. Name:

Relationship to you:

Address:

Postcode:

Contact Phone Number:

H. WORKING TIME REGULATIONS

I wish to work for 48 hours or more a week ☐

I do not wish to work for hours in excess of 48 hours a week ☐

I understand I may withdraw this consent by giving Flax Healthcare not less than 3-months notice. ☐

I. YOUR REFERENCE DETAILS

- Please supply the names and work addresses of 2 references.
- One must be from your present or most recent employer.
- Your references must either be 2 work related references, one work related and one character reference, but not 2 character references.

REFERENCE 1

Name: Position:

Address:

Postcode:

Daytime Phone Number: Other Phone Number:

Email address:

What was your professional relationship with this person?

Date: From: / To: /

REFERENCE 2

Name: Position:

Address:

Postcode:

Daytime Phone Number: Other Phone Number:

Email address:

What was your professional relationship with this person?

Date: From: / To: /

I hereby give permission for my referees to be contacted and for my references to be shared with third parties if necessary. Yes ☐

DBS REFERENCE

If you have a <u>**current or valid**</u> **CRB or DBS Certificate** or are on the **DBS UPDATE SERVICE**, provide your

DBS Reference Number:

J. YOUR BANK ACCOUNT DETAILS

Please tick A, B **or** C as applicable to you

A. I wish to be paid through an Umbrella Company of my choice and enclose details. ☐

Umbrella Company Name:

Umbrella Company email: Phone Number:

(You will be paid as P.A.Y.E until you provide all your documents to Flax Healthcare)

B. I am on P.A.Y.E ☐

(Please enclose a P45 Form if we are your main employer)

C. I have got my own Limited Company ☐

(IF YOU HAVE YOUR OWN LTD COMPANY, you MUST provide a copy of your Certificate of Incorporation, Company Bank details and proof of Indemnity Insurance. We can NOT make payments into a personal Bank Account.)

Account Holder / Business Account Name:

Name of Bank: Branch Name:

Sort Code: Account Number:

Branch Address: Postcode:

Please note that we will pay you weekly in arrears into your nominated account.

I confirm that the information I have given in this application, is to the best of my knowledge, true. I am permitted to work in the UK. I understand that my registration is subject to the receipt of at least two satisfactory references and an enhanced disclosure from the Disclosure and Barring Service (DBS). I undertake to inform Flax Healthcare Limited should I be convicted of an offence in the future. I undertake to inform Flax Healthcare immediately if I am engaged through their introduction, including the offer of permanent employment following a temporary assignment. I agree to respect the confidentiality of patients and any other information I may have access to, at all times. I am clear that Flax Healthcare cannot guarantee assignments and that they have no responsibility to pay for hours not worked, no matter the situation.

I confirm that I have been given a copy of the Staff Handbook and I confirm that I have read and understand the Code of Conduct set by Flax Healthcare.

Signed: ______________________ Date: ______________________