

**Application form**

**Name in full** \_\_\_\_\_ **Post applied for** \_\_\_\_\_

**Address** \_\_\_\_\_ **Do you know anyone who works here: yes / no**  
\_\_\_\_\_ **If yes, who?** \_\_\_\_\_

**Post Code:** \_\_\_\_\_ **State salary now required** \_\_\_\_\_

**Telephone No: (home)** \_\_\_\_\_ **Are you employed now?** \_\_\_\_\_

**Telephone No: (mobile)** \_\_\_\_\_ **If no, how long unemployed?** \_\_\_\_\_

**When can we contact you?** \_\_\_\_\_ **Have you applied here before** \_\_\_\_\_

**Date of birth** \_\_\_\_\_ **Do you suffer from any disability/ disease?** \_\_\_\_\_

**Place of birth** \_\_\_\_\_ **If yes state nature** \_\_\_\_\_

**Ethnic Origin** \_\_\_\_\_ **Approx. height** \_\_\_\_\_ **Approx. weight** \_\_\_\_\_

**Ages of children** \_\_\_\_\_ **Notice required to present employer** \_\_\_\_\_

**Single/ Married/ Widow/ Divorced/ Separated** **Have a current driving licence** \_\_\_\_\_

**Living in own home/ lodgings/ with parents/ renting**

**N.I No:** \_\_\_\_\_ **Preferred Hours:** \_\_\_\_\_

**Care Council for Wales Registration: Yes / No** **Registration Number:** \_\_\_\_\_

**Please give a brief description as to why you think you are suitable for the job, giving details of experience and qualifications obtained.**

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Have you ever been convicted of a criminal offence by a court of law (with exception of minor motoring offences or offences committed as a juvenile under the age of 16) **YES/ NO**

If yes please give details

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It is a statutory requirement by law for this home to obtain a **CRB** for all members of staff and therefore continued employment will not be confirmed in writing until a satisfactory check has been obtained even if you have completed your three-month probationary period. **CRB** checks are obtained through C A Francis, Cardiff.

### REFERENCES

<b>Present / Most Recent Employer</b>	<b>Other Referee</b>
<b>Name:</b>	<b>Name:</b>
<b>Job Title:</b>	<b>Job Title:</b>
<b>Address:</b>	<b>Address:</b>
<b>Post Code:</b>	<b>Post Code:</b>
<b>Telephone Number:</b>	<b>Telephone Number:</b>
<b>Relationship:</b>	<b>Relationship:</b>
<b>Length of Service:</b>	<b>Length of Service if Relevant:</b>

### Record of Sickness:

(Within last 12 months) \_\_\_\_\_ Reason: \_\_\_\_\_

Other information in support of your application \_\_\_\_\_

I can confirm that the information given by me on this form is correct

Signed \_\_\_\_\_ Date \_\_\_\_\_

**CONFIDENTIAL: MEDICAL QUESTIONNAIRE 1**

Full Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ N.I No: \_\_\_\_\_

**Please complete this questionnaire. As a result of the information you have given you may be referred to a doctor appointed by the home so that a medical examination can be carried out.**

Have you ever:	NO		YES	Please give details
a) Had an operation?				
b) Been seriously injured?				
c) Received in-patient treatment for a physical or mental condition?				
d) Been refused or dismissed from employment for health reasons?				
e) Received a disability pension?				
f) Been registered disabled?				<b>Card no:</b> _____ <b>Expiry date:</b> _____
g) Been made ill by your work?				
h) Been refused a driver's licence because of ill health?				

**To the best of my knowledge and belief the information given above is correct. I understand that if I am appointed and if the information I have provided is incorrect, I will be liable to dismissal.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

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**CONFIDENTIAL: MEDICAL QUESTIONNAIRE 11**

<b>Do you suffer from or have you ever had:</b>					
Diabetes	Yes / No	Skin rashes/ eczema	Yes / No	Swelling of legs/ankles	Yes / No
High Blood Pressure	Yes / No	Anaemia	Yes / No	Period or prostate problems	Yes / No
Asthma	Yes / No	Headaches (frequent)	Yes / No	Varicose veins	Yes / No
Shortness of breath	Yes / No	Heart trouble	Yes / No	Rupture	Yes / No
Cough (frequent)	Yes / No	Chest trouble	Yes / No	Hay fever	Yes / No
Arthritis	Yes / No	Fainting or dizziness	Yes / No	Ear trouble	Yes / No
Epilepsy/fits	Yes / No	Lung trouble	Yes / No	Eye trouble	Yes / No
Back trouble	Yes / No	Jaundice	Yes / No	Nerve trouble	Yes / No
Rheumatic Fever	Yes / No	Stomach trouble	Yes / No		Yes / No

<b>Do you:</b>				
<b>1.</b> Do you take medicine Regularly? YES / NO	<b>2.</b> Do you need Glasses to read? YES / NO	<b>3.</b> Have you worked in a dusty trade? YES / NO	<b>4.</b> Have you ever Had an injury? YES / NO	<b>5.</b> Do you currently suffer from any other ailments? YES / NO

**Any relevant additional information if required:**

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**To the best of my knowledge and belief the information given above is correct. I understand that if I am appointed and if the information I have provided is inaccurate, I am liable to dismissal.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Job title:** \_\_\_\_\_

STAFF