Kind Solutions Ltd
42-44 Clarendon Road, Watford WD17 1JJ
Tel:01923882925 Mob: 07948053259
Email: admin@kindsolutions.co.uk Website: www.kindsolutions.co.uk

JOB APPLICATION FORM
PRIVATE & CONFIDENTIAL

MR/MRS/ MISS/ MS (please delete as appropriate)	
FIRST NAME:	
MIDDLE NAME:	
SURNAME:	
DATE OF BIRTH:	
NATIONAL INS. NO.	
DBS CERTIFICATE NO.	
ADDRESS:	
POSTCODE:	
HOME TEL:	
MOBILE:	
E-MAIL:	
MARITAL STATUS:	
NEXT OF KIN:	
RELATIONSHIP:	
ADDRESS:	
POSTCODE:	
PHONE NUMBER:	
DO YOU HAVE PERMISSION TO WORK IN THE UK?	**YES / NO**
DO YOU HAVE A VALID PASSPORT?	**YES / NO**
YOU HAVE A VALID WORK PERMIT?	**YES / NO**
MOBILITY:	
DO YOU HAVE ACCESS TO A CAR	
WHICH CAN BE USED FOR WORK PURPOSES?	**YES / NO**
DO YOU HOLD A FULL UK DRIVING LICENCE?	**YES / NO**

QUALIFICATIONS/TRAINING

Qualifications	School/College	Grade/Result	Dates: From-To

Relevant Training/Qualifications in Healthcare		Certificates Date
Manual handling	YES/NO	
Health and safety	YES/NO	
Basic food hygiene	YES/NO	
First aid	YES/NO	
NVQ levels	YES/NO	
Medication	YES/NO	
Others (please list)	YES/NO	

EMPLOYMENT HISTORY / WORK EXPERIENCE

Please record all employment in the past 10 years, including current employment by other agencies, and any other relevant experience gained within the health care field. Please start with the most recent. **Please note that we shall obtain a reference from your LAST EMPLOYER**

Employer Name, Address & Tel no.	From	To	Position held, Duties and Responsibilities	Reason for Leaving

REFERENCES

1a) Must be your most recent employer (of at least 3 months duration) which must correspond with your employment history.

Name of Employer……...

Address of employer…….. ……

…….
.

Telephone Number ……...…….

E-mail ……...

Fax Number……..

1b) Another of your Employers in the last 3 years:

Name of Employer……...

Address of employer…….. ……

…….
.

Telephone Number ……...…….

E-mail ……...

Fax Number……..

2) Must be a fellow health care professional who does not live with you and is able to supply a character Reference of your personal and professional profile.

Name of Employer……...

Address of employer…….. ……

…….
.

Telephone Number ……...…….

E-mail ……...

Fax Number……..

HEALTH DECLARATION

Carers/Support workers are required to complete this Health Declaration. Any positive answers will not necessarily affect your application. Please list any medical conditions (past or present) which may affect your ability to do the job.

Occupational Health Assessment	Yes	No	Details
Are you in good health?			
How much time have you lost from work due to illness in the last five years? Please provide details			
Have you ever been treated in hospital for serious illness or surgery? Please give dates			
Have you been treated in hospital during the last 12 months?			
Do you have any physical disabilities that could affect your ability to carry out your assignment?			
Have you ever left, been retired or denied a job on health grounds?			
Have you ever been denied a driving licence on health grounds?			
Are you a registered disabled person?			
Have you any disability related to your physical or mental health?			
Have you ever suffered from any mental illness, psychological or psychiatric problems?			
Do you get discomfort or pain in the chest or shortness of breath on exercise?			
Have you ever had any problems with your joints, including pain, swelling or stiffness?			
Do you have any difficulty in moving rapidly over short distances?			
Would you have difficulty looking over either shoulder?			
Do you need to wear glasses or contact lenses?			
Do you have any difficulty with your eyesight which is not corrected by glasses or contact lenses?			
Have you any problems working with Visual Display Units?			
Have you any problems working in confined spaces/using lifts?			
Do you have any difficulty hearing normal conversation?			
Are you taking any medication that makes you dizzy or drowsy?			
Do you have a medical condition affected by changing sleeping patterns or affecting day time sleep?			
Have you suffered from any alcohol or drug related illness or had an alcohol or drug problem?			
Are you having or awaiting any treatment at the moment?			
What is the date of your last chest x-ray?			
Are you receiving Medicines, Pills or Tablets from a doctor or on prescription?			
Have you ever suffered from any of the following?			
Heart Problems/Circulatory Illness/Hypertension			
High or Low Blood Pressure			
Diabetes			
Asthma/Hay fever			
Bronchitis/Pneumonia/Pleurisy			
Tuberculosis			
Epilepsy/Fainting Attacks/Blackouts/Fits/Sudden Collapse			
Headaches/Migraine			
Psychiatric Illness/Anxiety/Depression			
Dermatitis/Skin Sensitivity/Psoriasis/Eczema/Allergies			
Back Injury/Back Problems/Back Pains			
Recurrent Infections e.g. Sore Throats/Ear Infections/Eye Infections			
Hepatitis/Jaundice			

Have you ever been Vaccinated, Immunized or Tested for / against any of the following?	**YES/NO**	**DETAILS**

Tuberculosis incl BCG, Heaf, Mantoux or Tine		
Rubella (German Measles)		
Poliomyelitis		
Hepatitis B		
Hepatitis B Antibodies Date and Result		
HIV		
Tetanus		
Typhoid		
Any Other		

DOCTOR INFORMATION
GP Name: Address: Postcode: Phone:

WORK PREFERENCE

To assist us in finding suitable work for you, please place a tick next to all specialties of which you have significant recent experience and are confident to carry out such duties.
Please keep us informed from time to time of all developments in your career as the work we assign to you depends on accurate up to date information.

WORK PREFERENCE: (Please tick)	
Full time / Part time *If part time, how many hours per week do you want to work...* *Home care and pop-in visits* *Hospitals* *Nursing/Residential Homes* *Morning / Day / Evening / Night Sleeper duty*	
Live-In Care	
Please state if you are able to work as a 24-hour Residential (live-in) Carer. *If YES, would you like:* *Long…… or short ……. assignments?*	*YES / NO*
Would you accept a live-in assignment some distance from your home? *If NO, please specify preferred areas:*	*YES / NO*

Care/Support Assistant ability schedule

Please indicate yes / No in the areas you have had previous experience.

Personal hygiene		***Care duties***	
bath/shower/strip wash	***Yes/No***	*Pressure area care*	***Yes/No***
bed bath	***Yes/No***	*Simple dressing procedure*	***Yes/No***
Use of bath aids	***Yes/No***	*Assisting with medication*	***Yes/No***
Shaving	***Yes/No***	*Terminal care*	***Yes/No***
Mouth care(inc. dentures	***Yes/No***		
Care of hair	***Yes/No***	***Practical tasks***	
Care of feet(exc. toe nails)	***Yes/No***	*Light house work*	***Yes/No***
Care of finger nails	***Yes/No***	*Washing personal laundry*	***Yes/No***
Dressing/undressing	***Yes/No***	*Shopping*	***Yes/No***
		Bed making/changing bed linen	***Yes/No***
Toileting		*Collecting benefits*	***Yes/No***
Continence care	***Yes/No***		***Yes/No***
Bedpans/commodes etc.	***Yes/No***	***Admin. Abilities***	
Changing a catheter bag	***Yes/No***	*Confidentiality*	***Yes/No***
Empting catheter bag	***Yes/No***	*Report writing*	***Yes/No***
		Recording instructions from GP/DISTRICT NURSE	***Yes/No***
Mobility		*Observing/recording*	***Yes/No***
Maneuvering and handling course	***Yes/No***	*Changes in clients condition*	***Yes/No***
Use of hoists(man./elec)	***Yes/No***	***Previous exp.***	
Use of walking aids	***Yes/No***	*Private house*	***Yes/No***
		Nursing/residential home	***Yes/No***

<u>EQUAL OPPORTUNITIES MONITORING</u>

Kind Solutions Ltd aims to be an equal opportunities employer. Employees are therefore put forward for work / shift irrespective of race, ethnic origin, disability, age and gender. In order

to monitor the effectiveness of our policy, we request all candidates to provide the following information.

Name .....……
Age Group 16 – 20 ○ 21 – 35 ○ 36 – 50 ○ 50+ ○

Registered disability	○
Unregistered disability	○
No disability	○

Please tick appropriately which best describes your Ethnic Origin.	
White European	○
White Other	○
Black African	○
Black Caribbean	○
Black Other	○
Indian	○
Pakistani	○
Chinese	○
Other	○

How did you hear about the post?

……

Are you related or do you know any member of staff at Kind Solutions Ltd?

……

REHABILITATION OF OFFENDERS ACT 1974

You are advised that you are not entitled to withhold information about convictions, which are regarded as spent under the Act'. This is due to the nature of the work involved renders the post exempt from sec. 4(2) of the Act in accordance with the Rehabilitation of Offenders Act 974 (Exceptions) Order 1975.
You are therefore required to give details of all convictions and cautions including 'spent' convictions. Any in formation, which you may give, will be strictly confidential and will be ***considered only*** *in relation to this or a similar position for which you may be considered with Kind Solutions Ltd.*

Have you ever been convicted of a criminal offence? ***YES*** *I* ***NO***

If ***yes****, please give details of all convictions and cautions, including spent convictions and cautions: (please use a separate sheet if necessary)*
……
……
……
……

You are required to complete the Disclosure and Barring Service's (DBS) form. All health professionals registered with Kind Solutions Ltd are subject to this disclosure process in the interests of all parties concerned.

DECLARATION

I declare that:

All information given is true in every respect. I have read and understood the Terms and Conditions and I agree to comply with the current Health and safety at work Act
(ii) I have never been charged with, or convicted of an offence under any legislation dealing with Residential care or any offence involving dishonesty or violence.
(iii) I have been issued with a staff handbook and informed of the importance of reading and understanding it.

Signature. …….…… Date…….……

DISCLOSURE AND BARRING SERVICE (DBS) – ENHANCED DISCLOSURE

Forenames ..... Surname .....

I understand that before I can commence work with Kind Solutions Ltd, I will need to be in possession of a DBS Enhanced Disclosure.

Signature..... Date ……. /……. /…….

DOCUMENTS NEEDED FOR REGISTRATION

• VALID WORK PERMIT
(Or if Student, College ID and Student Visa)

• BRITISH PASSPORT (or other current Home Office Document authorizing you to work in UK)

• NATIONAL INSURANCE (NI) CARD
(Or P45 or P60 or letter confirming you have applied for NI

• PROOF OF ADDRESS
E.g. Driving License, Utility Bill, or any formal letter with your name and address

• 1 CURRENT PASSPORT SIZE PHOTOGRAPH

• DISCLOSURE AND BARRING SERVICE CERTIFICATE (DBS) you apply with us or submit your current copy if you enrolled for online update.

• TRAINING CERTIFICATES, e.g. Moving & Handling, Basic Aid etc. If you do not have the certificates we can provide training

Candidate Payroll Form

(Please complete fields applicable to you in ALL SECTIONS)

Consultant:

Section 1: Candidate Details
Mr, Mrs, Miss, Ms:
First Name:
Surname:
Address:
Mobile Number:
Personal Email Address:
Date of Birth:
National Insurance Number (OR UTR Number):

Section 2: Limited Company		
Limited Company Name:		
Bank Details (Account Name):		
Account Number:		
Sort Code:		
Remittance Email Address:		
Registered for VAT:	YES	NO
Please Supply: • Certificate of incorporation • Proof of limited company bank details • VAT Certificate (If applicable)		

Section 3: Payroll company
Payroll Company Name:
Payroll company Tel:
Please Note: • If the candidate is using the services of a payroll services company, simply complete the above fields in section 3. • Please ensure the candidate is already registered with the aforementioned payroll company.

Section 4: PAYE
Bank Details (Account Name):
Account Number:
Sort Code:
Please Supply: • P45 OR P46

KIND SOLUTIONS LTD

OPTING OUT OF WORKING TIMES

I understand that legally, I do not have to work more than 48 hours per week on average based upon a 17 week average.

However, I would like to work more than 48 hours on average entirely of my own choice but I do not want to work more than……..hours per week on average.

We have agreed that I can alter or terminate this agreement by giving at least 14 days' notice in writing.

Name of employee: _____

Signature: _____

Date: _____

I accept the above employee has chosen of their own free will to opt out of the Working Time Regulations and that no pressure, whether intentional, unintentional, implied etc., has influenced or caused this decision. This agreement can be terminated by either party by giving at least 14 days' notice in writing.

Name of employer: _____

Signature: _____

Date: _____

IMPORTANT NOTE

ALL JOB APPLICANTS WHO FAIL TO SUBMIT OR DO NOT HAVE A FORM P45 MUST FILL A P46 FORM.

PLEASE ASK A MEMBER OF STAFF FOR A COPY, IF IT IS NOT ATTACHED ON THE APPLICATION FORM.

A COPY CAN BE DOWNLOADED OFF THE INTERNET- GOOGLE -P46 FORM.

HM Revenue & Customs

P46: Employee without a form P45

Section one To be completed by the employee

Your employer will need this information if you don't have a form P45 from your previous employer. Your employer may ask you to complete this form or provide the same information in another format. If you later receive your P45, hand it to your present employer. Use capital letters when completing this form.

Your details

National Insurance number
This is very important in getting your tax and benefits right

Title - *enter MR, MRS, MISS, MS or other title*

Surname

First name(s)

Gender. Enter 'X' in the appropriate box

Male ☐ Female ☐

Date of birth *DD MM YYYY*

Address

House or flat number

Rest of address including house name or flat name

Postcode

Your present circumstances

Read all the following statements carefully and enter 'X' in **the one** box that applies to you.

A - This is my first job since last 6 April and **I have not** been receiving taxable Jobseeker's Allowance, Employment and Support Allowance or taxable Incapacity Benefit or a state or occupational pension. A ☐

OR

B - This is now my only job, but since last 6 April **I have** had another job, or have received taxable Jobseeker's Allowance, Employment and Support Allowance or taxable Incapacity Benefit. I do not receive a state or occupational pension. B ☐

OR

C - I have another job or receive a state or occupational pension. C ☐

Student Loans (advanced in the UK)

If you left a course of UK Higher Education before last 6 April and received your first UK Student Loan instalment on or after 1 September 1998 and you have not fully repaid your Student Loan, enter 'X' in box D. *(Do **not** enter 'X' in box D if you are repaying your UK Student Loan by agreement with the UK Student Loans Company to make monthly payments through your bank or building society account.)* D ☐

Signature and date

I confirm that this information is correct

Signature

Date *DD MM YYYY* 2 0

Section two To be completed by the employer

Almost all employers must file employee starter information online at **www.hmrc.gov.uk/online**
Guidance for employers who must file online can be found at **www.businesslink.gov.uk/payingnewemployees**

Employers exempt from filing online should send this form to their HM Revenue & Customs office on the first payday. Guidance can be found in the E13 *Employer Helpbook Day to day payroll.*

Employee's details

Date employment started *DD MM YYYY*

Works/payroll number and department or branch (if any)

Job title

Employer's details

Employer PAYE reference
Office number *Reference number*

Employer name

Address

Building number

Rest of address

Postcode

Tax code used

If you do not know the tax code to use or the current National Insurance contributions (NICs) lower earnings limit, go to **www.businesslink.gov.uk/payeratesandthresholds**

Enter 'X' in the appropriate box

Box A
Emergency code on a **cumulative** basis A

Box B
Emergency code on a **non-cumulative** Week 1/Month 1 basis B

Box C
Code BR unless employee fails to complete section one then code 0T Week 1/Month 1 basis C

Tax code used

If Week 1 or Month 1 applies, enter 'X' in this box

For employees who complete Box A or Box B starter notification is not needed until their earnings reach the NICs lower earnings limit.

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Email: admin@kindsolutions.co.uk Website: www.kindsolutions.co.uk
Company registered number 09197093

Night Workers Health Questionnaire

This form is designed to help assess if you have any health condition, which could affect your ability to perform night work. The opportunity for an assessment is required by the Working Time Regulations 1998. This form asks specific questions about your health.

Employer:	Site:
Job Title:	Department:
Name:	GP Name:
Address:	GP Address:
Home Tel No:	
Date of Birth: / /	Employee's Sex: Male ❑ Female ❑

Please complete this form to the best of your knowledge and tick the appropriate box(es).

Please note that ticking "yes" does not necessarily mean you are unfit for night work (simply that you will need to be referred for further assessment).

1.	How long have you worked night shifts?	_____	
2.	Are you on permanent night shift?	Yes ❑	No ❑
3.	Do you suffer from diabetes?	Yes ❑	No ❑
4.	If yes, do you require insulin injections?	Yes ❑	No ❑
5.	Do you suffer from a heart condition or a circulatory disorder?	Yes ❑	No ❑
6.	If yes, does this affect your physical stamina and your ability to do physical work?	Yes ❑	No ❑
7.	Do you suffer from any stomach or intestinal disorder such as peptic ulcers or duodenal ulcers?	Yes ❑	No ❑
8.	Do you have any condition where the timing of a meal is particularly important?	Yes ❑	No ❑
9.	Do you suffer from any (medical) condition affecting your sleep?	Yes ❑	No ❑

10.	Do you suffer from a chronic chest disorder (such as asthma) where night- time symptoms are particularly troublesome?	Yes ❑	No ❑
11.	Do you suffer from any medical condition requiring regular medication at strict times e.g. epilepsy or thyroid disease?	Yes ❑	No ❑
12.	Have you had depression, "stress", nervous disorders or other mental illness, alcohol or drug addiction	Yes ❑	No ❑
13.	Are you aware of any other health factors that may affect your fitness to do night work or do you feel night shifts affect your health in any way?	Yes ❑	No ❑
14.	Please use the space below for any additional comments:		

Declaration:

I certify that the answers to the above questions are correct to the best of my knowledge and belief. I understand that if I have withheld information, this may adversely affect efforts to place me in suitable employment.

Employee's signature	Date:
Received by:	Date:

For office use only:

Fit for night work	☐
Fit for night work with restrictions	☐
Unfit for night work:	☐