



# Kosyken Care Services

KosyKen Care Services, is an Equal Opportunities Employer

## APPLICATION FORM

Attach  
photograph

### 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:

**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: \_\_\_\_\_

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

Do you smoke? YES / NO

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‘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: \_\_\_\_\_

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### 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: \_\_\_\_\_