



## Application Form

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

Date of Birth: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

P.P.S. Number: \_\_\_\_\_

\_\_\_\_\_

Female/Male: \_\_\_\_\_

\_\_\_\_\_

Nationality: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Eligibility to work e.g. Stamp/EU \_\_\_\_\_

Mobile Number: \_\_\_\_\_

Who referred you to the company:  
\_\_\_\_\_

E-mail Address: \_\_\_\_\_

Which area do you want to work:  
\_\_\_\_\_

Emergency contact: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Do you hold a full/clean drivers licence:

Telephone Number: \_\_\_\_\_

Yes  No  Own Vehicle

### Employment History

(Begin with your present and work backwards leaving no gaps)

Dates	Employers Name and Address	State your position and nature of your duties



### Education

Dates	School/College Attended	Qualification Obtained

### Training

Please indicate if you have received training in the following  
(Copies of all certificates to be included)

	Circle as Appropriate	Date of Training	Training provided by	Certificates included
FETAC Level 5 practical home care skills	Yes / No			
Patient Moving and Handling	Yes / No			
First Aid	Yes / No			
Dementia Care	Yes / No			
Infection Control	Yes / No			
Food Hygiene	Yes / No			
Fire Safety	Yes / No			
Abuse Awareness	Yes / No			
Safe Drug Awareness	Yes / No			
Protection of Vulnerable Adults	Yes / No			



## Referees

(All referees must be of manager level only that have directly supervised you at work)

<b>Full Name:</b> <b>Position:</b> <b>Company:</b> <b>Address:</b>  <b>Email address:</b> <b>Telephone:</b> <b>Fax:</b>	<b>Full Name:</b> <b>Position:</b> <b>Company:</b> <b>Address:</b>  <b>Email address:</b> <b>Telephone:</b> <b>Fax:</b>
<b>Full Name:</b> <b>Position:</b> <b>Company:</b> <b>Address:</b>  <b>Email address:</b> <b>Telephone:</b> <b>Fax:</b>	<b>Full Name:</b> <b>Position:</b> <b>Company:</b> <b>Address:</b>  <b>Email address:</b> <b>Telephone:</b> <b>Fax:</b>

### Confidential Health Declaration

Pre-placement assessment aims to ensure so far as is possible that you are fit for the post which you have applied. The contents of this form will remain confidential to the Sandra Cooney's Home Care and will not be revealed to anyone else without your written consent.

This questionnaire forms part of the appointments procedure and failure to declare a health problem or giving false information can result in the termination of your employment. A disability or health problem does not preclude consideration for the job and applications from suitable people with disabilities are welcome

General Practitioner:	Telephone No:
Address:	



### Previous Sickness Absence

(Time lost from work or school due to illness over last 2 years)

Length of Absence	Reason for Absence

Please answer **YES** or **NO** and If **YES**, Please Give Details In The Space Provided

		No	Yes	Details
1	Are you in good health at present?			
2	Have you ever been treated in hospital?			
3	Have you ever suffered a work related illness or accident, or given up work because of ill health?			
4	Do you smoke cigars/cigarettes/pipe/other			If YES, how many per week?
5	Do you drink alcohol?			If Yes, how much per week? Units
6	Are you having treatment of any kind at the moment?			
7	Are you waiting for any treatment or investigation?			
8	Have you been seen or examined by a doctor in the last 6 months?			
9	Do you have any problem with your vision or your eyes?			
10	Do you have an problem with your hearing or your ears?			
11	Do you have any physical limitation which may affect your ability to work?			
12	Have you ever had any kind of back problem leading to time off work?			
13	Have you ever had any kind of problems with your joints, including pain, swelling or restricted movements?			
14	Do you have any difficulty in standing, bending, lifting or other movements?			
15	Have you ever had any kind of skin problem?			
16	Have you ever had diabetes, thyroid or gland problem?			
17	Have you ever had seizures, blackouts or epilepsy?			
18	Have you ever had asthma, bronchitis or chest problems?			
19	Have you ever had Tuberculosis (TB)?			
20	Have you had a cough for more than 3 weeks in the last 12 months?			
21	Have you ever coughed up blood?			
22	Have you had any unexplained loss of weight or fever in the last 12 months?			
23	Has any member of your family suffered from TB?			
24	Have you ever had any mental illness?			
25	Have you ever sought help for mental, psychological or emotional problems?			
26	Have you ever had a drug or alcohol problem?			
27	Do you have any allergies?			
28	Have you ever had hepatitis or jaundice?			
29	Have you ever received treatment for a gastric or bowel problem?			



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

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

### Personal Pay Details

Please fill in the following information carefully and bring with you to interview

First Name	
Surname	
Address	
Mobile Phone Number	
Home Phone Number	
Email Address	
Date of Birth	
Staff Type	Care Worker
Bank Name	
Bank Address	
Account Number (8 numbers)	
Bank Sort Code (6 numbers)	
PPS Number	
Do you have a P45 from your previous employer?	