

Position applied for:

Location: **Date of Application**

PERSONAL INFORMATION	
Title	*Dr/Mr/Mrs/Miss/Ms/Other
Surname	
Forenames	
Address	
Postcode	
Telephone number	
Mobile number	
Email address	
Current UK driving licence	*Yes/No
Details of any endorsements	
Date of Birth	
National Insurance Number	
Nationality	
Work Permit No. (if applicable)	

EDUCATION	
Schools	Qualifications gained
College/University	Qualifications gained

*please delete as appropriate

EMPLOYMENT HISTORY Please list in chronological order (most recent first)

Where there are gaps in your employment history you must state a reason for this. Please note we are unable to process any applications that do not show a complete service record since leaving fulltime education.

Dates From / To	Name and address of employer	Job Title	Start/finish salary	Reason for leaving
/			/	
/			/	
/			/	
/			/	
/			/	
/			/	

Please explain reasons for any gaps in employment:

Notice required in current post:

HOBBIES & INTERESTS

GENERAL COMMENTS

Please list here your specific reasons for this application, your main achievements to date and the strengths you would bring to this post. Continue on a separate sheet if necessary.

CRIMINAL RECORD

Due to the nature of Ashmere's work we are exempt from the provisions of the *Rehabilitation of Offenders Act 1974 (exemptions) Order 1974*. You are therefore not entitled to withhold any information about convictions, cautions, reprimands and final warnings be them spent or otherwise. A successful applicant will also be required to complete an Enhanced Disclosure Check by the Criminals Record Bureau. Any information supplied here will be kept in strict confidence.

Have you ever been convicted of a criminal offence or received a caution, reprimand or warning?	Yes/No*
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If yes, please give details:

I hereby confirm that I have no criminal convictions that may render me unsuitable for employment within the vulnerable adult care sector:

Signed: Date:

*please delete as appropriate

QUALIFIED NURSES ONLY	
UKCC Pin Number:	

REFERENCES	
Please supply the names and addresses of your two most recent employers (four if applying for a Management Position), from whom we may obtain both character and work experience references.	
1. Name: Position: Company Name Address: Postcode: Telephone: Number of years known:	2. Name: Position: Company Name Address: Postcode: Telephone: Number of years known:
3. Name: Position: Company Name Address: Postcode: Telephone: Number of years known:	4. Name: Position: Company Name Address: Postcode: Telephone: Number of years known:

CONSANGUINITY			
Do you have a close personal relationship with any employee within Ashmere or its subsidiaries (i.e. partner, parent, grandparent, child, sibling, uncle, niece, etc or any such person's partner? If yes please give details below)			Yes/No*
Name	Position	Home	Relationship
Candidates who directly or indirectly seek the support of an existing employee for any appointment will be disqualified.			

*please delete as appropriate

EXPERIENCE QUESTIONNAIRE

To help us assess your range of abilities please complete **one** of the checklists below ticking any box where you have experience with helping people.

Experience Checklist for **Qualified Nurses**

<input type="checkbox"/> A&E	<input type="checkbox"/> Anaesthetics	<input type="checkbox"/> Burns & plastic	<input type="checkbox"/> Cardio thoracic
<input type="checkbox"/> CCU	<input type="checkbox"/> Dental nursing	<input type="checkbox"/> Dermatology	<input type="checkbox"/> Disabilities
<input type="checkbox"/> District nursing	<input type="checkbox"/> ENT	<input type="checkbox"/> Family planning	<input type="checkbox"/> Genito urinary
<input type="checkbox"/> Elderly care	<input type="checkbox"/> Gynae	<input type="checkbox"/> Haematology	<input type="checkbox"/> Industrial
<input type="checkbox"/> Infection Control	<input type="checkbox"/> ITU/ICU	<input type="checkbox"/> Learning disability	<input type="checkbox"/> Challenging behaviour
<input type="checkbox"/> MRI unit	<input type="checkbox"/> Medical	<input type="checkbox"/> Midwifery	<input type="checkbox"/> Nanny
<input type="checkbox"/> Neurology	<input type="checkbox"/> Occupational Health	<input type="checkbox"/> ODA/ODP	<input type="checkbox"/> Oncology
<input type="checkbox"/> Ophthalmics	<input type="checkbox"/> Orthopaedic	<input type="checkbox"/> Paediatric ICU	<input type="checkbox"/> Paediatrics
<input type="checkbox"/> Phlebotomy	<input type="checkbox"/> Practice Nursing	<input type="checkbox"/> Acute psychiatry	<input type="checkbox"/> EMI psychiatry
<input type="checkbox"/> Long Stay psychiatry	<input type="checkbox"/> Forensic psychiatry	<input type="checkbox"/> Radiography	<input type="checkbox"/> Recovery
<input type="checkbox"/> Renal dialysis	<input type="checkbox"/> SCBU	<input type="checkbox"/> Screening	<input type="checkbox"/> Social Work
<input type="checkbox"/> Surgical	<input type="checkbox"/> Terminal Care	<input type="checkbox"/> Theatre	<input type="checkbox"/> X ray

Or Experience Checklist for **Nursing Auxiliaries, Care, and Support Workers**

<input type="checkbox"/> Blood pressure	<input type="checkbox"/> Temperature	<input type="checkbox"/> Respiration	<input type="checkbox"/> Weight charts
<input type="checkbox"/> Pulse	<input type="checkbox"/> Urine testing	<input type="checkbox"/> Obtain <i>simple</i> specimens	<input type="checkbox"/> Dressing/Undressing of patients
<input type="checkbox"/> Bath/shower/strip wash	<input type="checkbox"/> Use of bath aids	<input type="checkbox"/> Mouth care (inc. dentures)	<input type="checkbox"/> Care of feet (ex. toenails)
<input type="checkbox"/> Bed Bath	<input type="checkbox"/> Shaving	<input type="checkbox"/> Care of hair	<input type="checkbox"/> Care of fingernails
<input type="checkbox"/> Care of eyes	<input type="checkbox"/> Care of bladder & bowels	<input type="checkbox"/> Use of bedpan/commodes	<input type="checkbox"/> Emptying catheter bag
<input type="checkbox"/> Changing colostomy bag	<input type="checkbox"/> Recording fluid balance	<input type="checkbox"/> Moving & handling	<input type="checkbox"/> Use of walking aids
<input type="checkbox"/> Use of hoist	<input type="checkbox"/> Preparation of meals	<input type="checkbox"/> Feeding a patient	<input type="checkbox"/> Pressure area monitoring
<input type="checkbox"/> Ensuring medication has been taken	<input type="checkbox"/> Simple dressing procedures	<input type="checkbox"/> Changing bedding	<input type="checkbox"/> Sitting with a terminally ill patient
<input type="checkbox"/> Dealing with relatives of ill & terminally ill patient	<input type="checkbox"/> Observing client confidentiality	<input type="checkbox"/> Report writing/giving	<input type="checkbox"/> Record instructions from GP/district nurse
<input type="checkbox"/> Observation & reporting of patient condition	<input type="checkbox"/> Light housework	<input type="checkbox"/> Experience in care homes	<input type="checkbox"/> Experience with dementia
<input type="checkbox"/> First aid	<input type="checkbox"/> Assisted with occupational therapy, inc. recreation, sport & play	<input type="checkbox"/> Answering the telephone	

Please use this space to include and information/comments to support your application.

CURRENT HEALTH		If yes, give full details (if necessary use a separate sheet)	
The information which you provide will be used to assess your suitability for employment. Please note that giving false information may result in the withdrawal of the offer of employment or dismissal, if you have already commenced employment. Any information you give will be treated in confidence.			
1	Are you currently taking any medication or receiving any medical treatment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2	Are you subject to periodic checks of any kind?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3	Are you awaiting any operation or other medical investigation or treatment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4	Is there any impairment or limitation to your eyesight, hearing or mobility?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5	Do you consider yourself disabled?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

PAST HEALTH		If yes, give full details (if necessary use a separate sheet)	
6	How many days have you been absent from work in the last 12 months due to ill health?		
7	Have you ever been treated for any of the following conditions or had your activities limited by their symptoms?		
A	Chest pains, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack, angina or other disorder of the heart or circulatory system.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
B	Asthma, bronchitis, emphysema, pneumonia, spitting of blood or other disorder of the respiratory system.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
C	Gastric or duodenal ulcer, hernia, colitis, Crohn's disease or diarrhoea lasting more than two weeks, jaundice, hepatitis, any other disorder of the liver, stomach or bowel.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
D	Kidney stones or any other disorder of the kidneys or bladder.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
E	Diabetes or any thyroid or glandular disorder.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
F	Arthritis, gout, rheumatism, backache, or any other problem causing pain in or affecting the function of your muscles or joints, including any fractures.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
G	Tenosynovitis, tendonitis, epicondylitis, carpal tunnel syndrome, stenosing vaginitis, De Quervain's syndrome, cervical spondylosis, frozen shoulder or any similar condition.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
H	Convulsions, epilepsy, fits, blackouts, paralysis, stroke, severe headaches or chronic fatigue.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I	Nervous breakdown, depression, stress anxiety.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
J	Any form of mental incapacity.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

PAST HEALTH (continued)		If yes, give full details (if necessary use a separate sheet)	
K	Leukaemia, lymphoma, Hodgkin's disease or cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
L	An exposure to HIV/Hepatitis B/Hepatitis C or the virus itself.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
M	Have you ever been refused employment or had any employment terminated on grounds of ill health?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

DOCTOR INFORMATION	
Name of GP	
Address	
Postcode	
Telephone number	

Declaration

- I confirm that the above information is complete and correct, and that any untrue or misleading information will give my employer the right to terminate any employment contract offered.
- I hereby give my authority for the company to contact my own doctor to obtain any further information on my state of health.
- I agree that the company reserves the right to require me to undergo a medical examination in the event of my appointment.
- I hereby give my consent to the company processing the data supplied on this application for the purpose of recruitment and selection.

Signed: **Date:**

Printed:

EQUAL OPPORTUNITIES	
<p>Ashmere aims to select new employees based only on their ability to undertake the specified job. Every prospective employee will be treated fairly and solely on the grounds of merit. At no time will gender, marital status, age, disability, nationality, ethnic origin sexual orientation or religion be a determining factor in recruiting a new employee.</p> <p>Ashmere is fully committed to the active promotion of equal opportunity, both when delivering our broad range of services and in the community.</p>	
Sex	Male <input type="checkbox"/> Female <input type="checkbox"/>
Ethnic Origin	White European <input type="checkbox"/> White other <input type="checkbox"/> Asian <input type="checkbox"/> South East Asian <input type="checkbox"/> Black African <input type="checkbox"/> Caribbean <input type="checkbox"/> Other (please specify)
Do you have any disabilities?	Yes <input type="checkbox"/> No <input type="checkbox"/> (if yes please specify)
Would you require Ashmere to make any reasonable adjustments (under the Disabilities Discrimination Act) that would allow you to fulfil the requirements of the position applied for?	Yes <input type="checkbox"/> No <input type="checkbox"/> (if yes please specify)

ADDITIONAL INFORMATION

COMPANY USE ONLY			
Candidate name			
Position			
Comments			
To interview		Yes <input type="checkbox"/> No <input type="checkbox"/>	Interview date
Justification			
Decision taken by		Sign	Date
Candidate successful		Yes <input type="checkbox"/> No <input type="checkbox"/>	Commencement date
Sent to head office	BACS Yes <input type="checkbox"/> No <input type="checkbox"/>	P45/P46 Yes <input type="checkbox"/> No <input type="checkbox"/>	Photo Yes <input type="checkbox"/> No <input type="checkbox"/>
Reference 1	Sent	Received	
Reference 2	Sent	Received	
POVA	Requested date	Received	
CRB	Requested date	Ref. Number	
Payroll number			