LAMBETH CARE SERVICES LIMITED

LAMBETH CARE Services Limited, is an Equal Opportunities Employer

Attach photograph

APPLICATION FORM

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:
LAMBETH CARE SERVICES LIMITED, EasyHub Croydon 22 Addiscombe Road, Croydon, CR0 5PE
info@lambethcareservices.co.uk

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: _____

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

Do you smoke? YES / NO

'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:_____

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 **Lambeth Care Services Ltd**._____

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: _____