Branch:	Type of Work:	Date Reg'd: ___/___/___

Social Worker Application Form

Personal Details		
Title: Mr / Mrs / Miss / Ms Other:		**Marital Status:**
Surname:		**Maiden Name:**
Forename(s):		**Known As:**
Place of Birth:		**Nationality:**
DOB: ___/___/___**	**Age:**	**Gender:** Male ☐ Female ☐
Address:		**Home Telephone:**
		Other Telephone:
		Mobile Telephone:
		E-Mail Address:
	Postcode:	**Do You Smoke:** Yes ☐ No ☐
National Insurance Number ___ ___ ___ ___ ___ ___ ___ ___ ___		
Where Did You Hear Of Network Healthcare?		

**Please note due to Age Discrimination Legislation you do not have to provide this information by Law.

Bank Details	
Bank / Building Society Name:	**Account Holders Name:**
Account Number ___ ___ ___ ___ ___ ___ ___ ___	**Sort Code** ___ ___ --___ ___ -- ___ ___
Roll Number (Building Societies Only)	

Employment Eligibility	
Do you need a visa to work in the UK?: Yes ☐ No ☐	**Type of visa held?:**
How long Have you been in the UK?:	**Visa expiry date?:**

Flexibility & Availability	
Do you hold a UK driving licence? Yes ☐ No ☐	**Do you have your own transport?** Yes ☐ No ☐
Are you able to accept early/late calls? Yes ☐ No ☐	**What type of transport do you have?**

Union Details	
Do you belong to a Union? Yes ☐ No ☐	**Name of Union**
Membership Number:	**Union Expiry Date:**

Next of Kin (In case of Emergencies)		
Name:		**Relationship:**
Address:		**Home Telephone:**
		Work Telephone:
	Postcode:	**Mobile Telephone:**

Education, Qualifications & Training
(Please Include Dates of Attendance)

Secondary School:	**Grades:**
Further Education / Training:	**Grades / Qualifications:**
Additional / Professional Qualifications:	**Grades / Qualifications:**
Any Additional Information:	

Languages

Native Language	**Sign Language** Yes ☐ No ☐
Second Language	**Third Language**
Fourth Language	**Fifth Language:**

Key Skills

Are you HCPC Registered? Yes ☐ No ☐	**Did You Train** In the UK ☐ Overseas ☐
When did you apply for registration? __ / __ /__	**Your HCPC Number:**
Please provide details of training and qualifications obtained:	

Skills (Please tick relevant box)	**Less Than 6 Months**	**More Than 6 Months**	**1 to 2 Years**	**More than 2 years**
Adolescents				
Adults				
Advice & Assessment				
Child Protection Worker				
Children				
Drug / Alcohol Abuse				
Educational Social Worker				
Family Centre Work				
Fostering / Adoption Worker				
Generic / Duty Field Worker				
Homeless				
Probation Services				
Residential				
Social Work Team Leader				

Grade of Worker:

CSS ☐ DipSW ☐ CRSW ☐ CRCCYP☐ DTMHA ☐ PCSC ☐ ICSC ☐
NVQ ☐ PQS ☐ PQSW ☐ AASW ☐ ASW ☐ RSW ☐ CQSW ☐

Employment History

Please start with your most recent employer and ensure all gaps are accounted for.
Continue on a blank piece of paper if necessary

Name & Address of Employer	**Job Title**	
	Start Date:	**Leave Date:**
	Reason for Leaving:	
Reference Contact:	**Telephone Number:**	
Responsibilities		

Name & Address of Employer	**Job Title**	
	Start Date:	**Leave Date:**
	Reason for Leaving:	
Reference Contact:	**Telephone Number:**	
Responsibilities		

Name & Address of Employer	**Job Title**	
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Name & Address of Employer	**Job Title**	
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Responsibilities		

Name & Address of Employer	**Job Title**	
	Start Date:	**Leave Date:**
	Reason for Leaving:	
Reference Contact:	**Telephone Number:**	
Responsibilities		

Reference Contacts

To be able to fully register you, Network Healthcare needs to get a minimum of three professional references covering you for at least the past 5 years. This means they must be from your previous employers, one of which should be your most recent employer, so please include the business address.

Name of Referee:	**Telephone Number:**
Position of Referee:	**Fax Number:**
Company Name	**E-Mail Address:**
Address:	
	Postcode:

Name of Referee:	**Telephone Number:**
Position of Referee:	**Fax Number:**
Company Name	**E-Mail Address:**
Address:	
	Postcode:

Name of Referee:	**Telephone Number:**
Position of Referee:	**Fax Number:**
Company Name	**E-Mail Address:**
Address:	
	Postcode:

Name of Referee:	**Telephone Number:**
Position of Referee:	**Fax Number:**
Company Name	**E-Mail Address:**
Address:	
	Postcode:

Name of Referee:	**Telephone Number:**
Position of Referee:	**Fax Number:**
Company Name	**E-Mail Address:**
Address:	
	Postcode:

Name of Referee:	**Telephone Number:**
Position of Referee:	**Fax Number:**
Company Name	**E-Mail Address:**
Address:	
	Postcode:

Name of Referee:	**Telephone Number:**
Position of Referee:	**Fax Number:**
Company Name	**E-Mail Address:**
Address:	
	Postcode:

Name of Referee:	**Telephone Number:**
Position of Referee:	**Fax Number:**
Company Name	**E-Mail Address:**
Address:	
	Postcode:

Health Declaration & Medical History

All employees are required to complete this Health Declaration.
Your answers will not necessarily affect your application.

General Practitioner or Occupational Health Department:	
Address:	
Postcode:	**Telephone Number:**

	Yes	No	Details
Have you ever been treated at a hospital for serious illness or surgery? (Please give details)			
Have you been absent from work due to illness in the past five years? (Please give details)			
Are you a registered disabled person? (Please give Details)			
Have you had a chest x-ray? If so when? (Please give details)			

Have you suffered from any of the following?

Heart / Circulatory Illness / Hypertension			
Diabetes			
Asthma / Hayfever			
Bronchitis / Pneumonia / Pleurisy			
Tuberculosis			
Epilepsy / Frequent Fainting Attacks			
Headaches / Migraine			
Psychiatric Illness / Anxiety / Depression			
Dermatitis / Skin Sensitivity (Allergies) / Psoriasis / Eczema			
Back Injury / Back Problems / Back Pains			
Recurring Infections e.g. Sore Throats, Ear Infections			
Hepatitis			
Jaundice			
Are you receiving any Medicines, Pills or Tablets from a Doctor or on Prescription? (Please give details)			
Do you have any other physical disabilities other than those listed above that could affect your ability to carry out your assignment? (Please give details)			

Have you ever been Vaccinated, Immunised or Tested for / against any of the following:

Varicella			
Tuberculosis including BCG			
Heaf, Mantoux or Tine			
Rubella (German Measles)			
Poliomyelitis			
Hepatitis B			
Hepatitis B Antidotes Date & Result			
HIV			
Tetanus			
Typhoid			
Any Other:			

If you do not have vaccination information, please provide details of where we can request this information e.g. Hospital/GP/Occupational Health. _____

_____

Please Sign to authorise this request _____

Rehabilitation of Offenders Act 1974

Because of the nature of the work for which you are applying, this post is exempt from the provisions of Section 4.2 of the Rehabilitation of Offenders Act 1974 (exemption Order 1975). Applicants are therefore, not entitled to withhold information about convictions, which for other purposes are 'spent' under the provisions of the act and in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action. Any information given will be completely confidential and will be considered only in relation to an application for positions in which the Order applies, and should be entered at the end of any particulars you give in support of your application.

Have you ever been convicted of a criminal offence? Yes ☐ No ☐

Have you instigated an enhanced disclosure within the last 6 months? Yes ☐ No ☐
With an Enhanced Disclosure, under 4.2 of the Rehabilitation of Offenders Act 1974 (Exemption Order), all previous cautions, warnings and convictions will always be detailed regardless of how long ago they occurred.

Do you have any spent or unspent criminal convictions? Yes ☐ No ☐
Any conviction, caution, reprimand will require a written statement of each and every event and how it does not affect your suitability for the role you are applying for.

Have you supplied additional information with this application for any spent or unspent convictions, cautions or reprimands? Yes ☐ No ☐

Have you ever been involved in Court Proceedings? Yes ☐ No ☐

Please give any additional information, which you think may be relevant in support of your application on a separate page.

I confirm that the information I have provided in support of this application is complete and true and understand that knowingly to make a false statement could be a criminal offence.	**Signature:**
	Date:

I consent to Network Healthcare Limited checking the details that I have provided in support of this application against various data sources in order to verify my identity and process this application. These details may be recorded and used to assist other organisations for identity verification purposes such as the CRB, regulatory bodies such as NMC or GSCC.	**Signature:**
	Date:

The information that I have given in this registration 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 Network Healthcare Limited. I also agree to keep Network Healthcare Limited advised of any changes to any of the information supplied.

Signature:	**Date:**
Print Name:	**Consultant Signature:**