



nurseplus<sup>™</sup>

# Employment Application Form

FOR OFFICE USE ONLY

Applicant's Name

Position applied for

Ref No.

Client Group/Area of work

Source of Application

Date application was received

## Interview Details

To be interviewed YES  NO

If No, please give details \_\_\_\_\_

Interview Date: \_\_\_\_\_

Interview Time: \_\_\_\_\_

Interviewers: \_\_\_\_\_

\_\_\_\_\_

**A Leading Provider  
of Care and  
Support Services  
across Scotland.**

All information provided by applicants will be treated as confidential. Full and accurate details are required, any inaccuracy or omission in the information supplied will prejudice employment.

**Please answer all questions as fully as possible.**

**Personal** (PLEASE COMPLETE THIS SECTION IN BLOCK CAPITALS)

Surname _____	Forenames _____
Address _____	
_____	
_____	
_____	Postcode _____
_____	
Home Telephone No. _____	Mobile Telephone No. _____
Email _____	National Insurance No. _____
Next of Kin _____	
Next of Kin Address _____	
_____	
_____	
Postcode _____	
_____	
Next of Kin Telephone No. _____	
Relationship to Applicant _____	

Are you involved in any activity which entitles you to time off? e.g T.A., Trade Union Rep., Childrens Panel, etc.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever worked for this Company before?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you applied for employment with this Company before?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you related to any person employed by this Company?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If you answered Yes to any of the above questions, please give full details: _____		
_____		

<b>Eligibility to work</b>		
Do you need a work permit to take employment in the UK?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have a current and valid passport?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If successful, you must provide satisfactory evidence of your eligibility to work in the UK.		

Are you looking for: Full-Time <input type="checkbox"/>	Part-Time <input type="checkbox"/>	Relief Work <input type="checkbox"/>
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Where did you hear of this vacancy?   
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**Education - Please detail all educational & vocational qualifications**

School Qualifications	From	To	Examinations and Results

College or University	From	To	Courses and Results

Further Formal Training	From	To	Diploma / Qualification

Job Related Training Courses	Name of Organisation	Date	Subject

Please give details of membership of any technical or professional associations, including details of any volunteer work you may be or have been involved in.

NMC Pin Number \_\_\_\_\_ Expiry Date \_\_\_\_\_

RCN or other professional union membership number \_\_\_\_\_ Expiry Date \_\_\_\_\_

Name and address of training hospital and any position held there \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Current Details

Are you currently employed? Yes  No

If No, provide details \_\_\_\_\_

Name of present employer: \_\_\_\_\_

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

\_\_\_\_\_ Postcode: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail address: \_\_\_\_\_

Nature of Business: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

How much notice are you required to give your current employer? \_\_\_\_\_

Job Title	Brief Description of Your Duties

Length of Service From: \_\_\_\_\_ To: \_\_\_\_\_

Current Annual Salary: \_\_\_\_\_

Please confirm whether this is your only job? Yes  No

If No, please give full details: \_\_\_\_\_

\_\_\_\_\_

## Previous Employment Details

You must account for any gaps in employment since leaving school. Please continue on a separate sheet if necessary.

Name and Address of Employer	Dates	Position Held / Main Duties	Reason for Leaving	Salary

## Previous Employment Details continued

Name and Address of Employer	Dates	Position Held / Main Duties	Reason for Leaving	Salary

## Interests, Achievements, Leisure Activities, Volunteering (eg hobbies, sports, club memberships)

## References

Please give the names and addresses of your two most recent employers (one of which must be your current employer and one must be a previous employer) whom we will approach for a reference.

It is our company policy to collect references prior to any offer of employment.

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

Company Name: \_\_\_\_\_

Position: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Telephone No: \_\_\_\_\_

Fax No: \_\_\_\_\_

E-Mail address: \_\_\_\_\_

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

Company Name: \_\_\_\_\_

Position: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Telephone No: \_\_\_\_\_

Fax No: \_\_\_\_\_

E-Mail address: \_\_\_\_\_

Reference details confirmed at interview

## Additional Information

Please detail any relevant experience you can bring to this role and why you feel you are the best candidate for this position. Please also give details of your aspirations, personal strengths and goals for the future. Continue on a separate sheet if necessary.

## Rehabilitation of Offenders Act 1974

Our recruitment process is compliant with “The Rehabilitation of Offenders Act 1974 (Exclusions and Exceptions) (Scotland) Order 2003 as amended” and entitles us as providers of care services, to conduct an enhanced disclosure check to confirm candidate suitability for employment in this sector. You are therefore required to provide details of all convictions whether they be current, pending or expired. You should be aware that any convictions including for example - unpaid TV licence, driving convictions, including speeding offences, admonished convictions and any warnings or cautions you have received since the age of 16 will be highlighted on your disclosure certificate. Please refer to [www.disclosurescotland.co.uk](http://www.disclosurescotland.co.uk) for more information on Disclosure Scotland’s ‘code of practice’.

Have you read the above statement? Yes  No

Have you ever been the subject of disciplinary action with the H.M Forces and/or Professional Bodies, including the Police Force? Yes  No

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

Do you have any pending charges you wish to declare to us? Yes  No

If you have answered “yes” please state when, the court, the offence and disposal.

Please list any convictions/pending charges below: _____ _____ _____
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PLEASE NOTE: That all ILS staff are required to inform the HR Manager of any convictions subsequently obtained after their appointment.

Full Driving Licence: Yes <input type="checkbox"/> No <input type="checkbox"/> Access to Car: Yes <input type="checkbox"/> No <input type="checkbox"/>
Endorsements (current and expired): Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes please give details and dates: _____ _____
Driving licence No. _____

PLEASE NOTE: If successful, you must provide valid copies of your business insurance policy, MOT and Road Tax. Annual updates will apply.

### Declaration

I should like to confirm that I am agreeable to Independent Living Services undertaking an Enhanced Disclosure Check, in relation to the Protection of Vulnerable Groups (Scotland) Act 2007, with Disclosure Scotland to ascertain whether or not I have any convictions or court appearances recorded in their files.

I declare that the information given in this form is complete and accurate. I understand that any false information or deliberate omissions will disqualify me from employment or may render me liable to summary dismissal.

Signed: _____	Date: _____
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**FOR OFFICE USE ONLY - Interview Assessment Form**

**SECTION A  
to be completed by Interviewer**

Comments of Suitability/Competency for Position.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Process to Continue:  YES  NO

- Full Time  Part Time  Relief
- Sleepover  WNS  No Overnights
- Alternate Weekends  One Day Each Weekend

Confirmed

**CONTRACT EXPLAINED**

Confirm details of Full Time/39 Hours, Part Time & Relief Contracts

**INDUCTION TRAINING**

3 Days Unpaid

**PAYMENT**

Monthly/Weekly in Arrears by Timesheets

**TRAVEL /EXPENSES**

Only when agreed and advised by Co-ordinator

**SICK PAY**

SSP, Proper Certification Required

**ANNUAL LEAVE**

24 Days Paid or Pro rata

**REGISTERED NURSES ONLY**

Confirmed

Night Shift

Shift/Working Patterns Explained

**ANNUAL LEAVE**

20 Days plus 8 Public Holidays

NMC Check

RCN Card Copied

All Professional Certificates copied, Professional Profile Reviewed

Health Questionnaire Satisfactory  YES  NO

Driving Licence Checked & Copied

Birth Certificate Checked & Copied

Business Insurance Requirement

Passport Checked & Copied

Work Permit Checked & Copied

Qualifications Checked & Copied

Rehabilitation of Offenders Act Explained

Back Injury

Annual Leave Booked

If Yes, give details \_\_\_\_\_

**CONTRACT ON OFFER**

Full Time/39 Hours  Relief

Part Time

Reason why full time contract not issued \_\_\_\_\_

\_\_\_\_\_

**Decision (based on interview)**

SUCCESSFUL  UNSUCCESSFUL

**Signed off by Interviewer**

Signature: \_\_\_\_\_

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

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | YES                      | NO                       |
| Interview questions satisfactory           | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 satisfactory verbal references received  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 satisfactory written references received | <input type="checkbox"/> | <input type="checkbox"/> |

**SECTION B to be completed by Recruitment Team**

Training Dates: \_\_\_\_\_

Start Date: \_\_\_\_\_

Client Group: AC CFY OP

Assigned Co-ordinator: \_\_\_\_\_

\_\_\_\_\_



# Health Questionnaire

## Confidentiality

The information given on this form shall not be disclosed WITHOUT YOUR PERMISSION. The purpose of this health questionnaire is to make sure that you are fit to carry out the duties asked of you, and that those duties could not trouble you medically.

Please complete this questionnaire and return with Application Form etc. Please complete in BLACK INK and CAPITALS.

Surname: \_\_\_\_\_ Mr / Mrs / Ms / Miss Forenames: \_\_\_\_\_

Previous Surname(s): \_\_\_\_\_

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

\_\_\_\_\_ Postcode: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

**Occupational History** Please give details of the your last 3 jobs, employers and any hazards you were exposed to (e.g. dangerous chemicals, noise levels etc.)

	Occupation	Employer	Dates	Hazard
1.				
2.				
3.				

During the past 3 years have you been absent from work due to illness, injury or education for a period of 2 weeks or more? Please give details:

\_\_\_\_\_

How many absences due to sickness have you had in the past year? \_\_\_\_\_

Total number of days: \_\_\_\_\_

**Social History** Please tick/complete as appropriate

Never smoked  Used to smoke  until years / months ago \_\_\_\_\_

Smoke now  Cigarettes per day  Cigars per day  Packets of tobacco per week

Average weekly alcohol intake: Beer  Wine  Spirits  Pints  Glasses  Measures

Exercise: State type of exercise and hours per week

\_\_\_\_\_

Please answer ALL the questions. Please complete in BLACK INK and CAPITALS.

Please tick the appropriate box - if YES give details in right-hand column (with dates where applicable)



	YES	NO		YES	NO
1. Are you currently receiving any medical treatment/medicine/injections or attending the hospital or your GP?	<input type="checkbox"/>	<input type="checkbox"/>	15. Asthma, bronchitis, tuberculosis or other chest problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had a medical or health assessment in the last 3 years?	<input type="checkbox"/>	<input type="checkbox"/>	16. Arthritis or rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had any operations or injuries which required hospital treatment or investigation?	<input type="checkbox"/>	<input type="checkbox"/>	17. Blood disorders or anaemia?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you lived, or worked abroad within the last 10 years?	<input type="checkbox"/>	<input type="checkbox"/>	18. Diabetes or thyroid disorder?	<input type="checkbox"/>	<input type="checkbox"/>
5. Back, neck, shoulder or other joint problem including slipped disk or strain?	<input type="checkbox"/>	<input type="checkbox"/>	19. Chronic or repeated infections?	<input type="checkbox"/>	<input type="checkbox"/>
6. Chest pain on effort?	<input type="checkbox"/>	<input type="checkbox"/>	20. Skin conditions eg. eczema, dermatitis?	<input type="checkbox"/>	<input type="checkbox"/>
7. Pain in your legs when walking?	<input type="checkbox"/>	<input type="checkbox"/>	21. Eye conditions, colour blindness or poor vision?	<input type="checkbox"/>	<input type="checkbox"/>
8. Weakness or limited movement in your back, arms, neck or legs?	<input type="checkbox"/>	<input type="checkbox"/>	22. Do you wear spectacles or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
9. Tonsillitis, sinusitis or ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	23. Ear condition including deafness? Please indicate if you wear a hearing aid.	<input type="checkbox"/>	<input type="checkbox"/>
10. Fits, fainting attacks, giddiness, blackouts or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	24. Hernia (rupture)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Nervous illness, including 'nervous breakdown', anxiety or depression?	<input type="checkbox"/>	<input type="checkbox"/>	25. Migraine or frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
12. Heart trouble, angina or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	26. Varicose veins or disorders of feet?	<input type="checkbox"/>	<input type="checkbox"/>
13. Gastric or duodenal ulcer or other digestive or bowel disorders?	<input type="checkbox"/>	<input type="checkbox"/>	27. Jaundice or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
14. Kidney or bladder conditions?	<input type="checkbox"/>	<input type="checkbox"/>	28. Allergies or hay fever?	<input type="checkbox"/>	<input type="checkbox"/>
			29. Breathlessness when walking or climbing?	<input type="checkbox"/>	<input type="checkbox"/>
			30. Are there any aspects of your health or any medical conditions not covered which the Occupational Health Services should be made aware of?	<input type="checkbox"/>	<input type="checkbox"/>
			31. Immunisation against hepatitis B and rubella?	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered yes to any of the above, please give full details and dates (please continue on a separate sheet if necessary):

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## Declaration

- I declare that all the foregoing statements are true to the best of my knowledge.
- I understand and accept that I may be required to attend an Occupational Health Assessment.
- I understand and accept that further medical information may be requested from any doctor if considered necessary and subject to the Occupational Health Adviser obtaining my consent under the Access to Medical Reports Act 1988.

Name (BLOCK CAPITALS):

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

# Equal Opportunities Monitoring Form

Applicants Name \_\_\_\_\_

We would appreciate if you could complete and return this form with your application. The information is used for equal opportunities monitoring purposes and does not form any part of the selection process.

Successful candidates will have information retained in their personnel file for statistical review purposes. Otherwise, forms will be shredded after the relevant information has been extracted for statistical purposes. This does not include details of individuals names.

## 1. ETHNIC ORIGIN

What do you consider to be your ethnic group?

- White  
 Mixed  
 Asian  
 Black

Or other Ethnic background. Please give details

\_\_\_\_\_  
 \_\_\_\_\_

## 2. AGE

- 18 - 24       40 - 44  
 25 - 29       45 - 49  
 30 - 34       50 - 54  
 35 - 39       55+

## 3. DISABILITY

Do you consider yourself to have a disability which may affect your work or require modification to working practice or environment?

- Yes       No

If Yes, is your disability:

- Physical       Non Physical

## 4. NATIONALITY

- British       Other (please specify)

\_\_\_\_\_

## 5. GENDER

- Male       Female

## 6. MARITAL STATUS

- Married       Not Married  
 (please specify)

## 7. RELIGIOUS BELIEF

What religion, religious denomination or body do you belong to?

- None       Roman Catholic  
 Church of Scotland  
 Other Christian (please specify)

\_\_\_\_\_

- Buddhist       Muslim  
 Hindu       Sikh  
 Jewish

Another Religion (please specify)

\_\_\_\_\_



Please return completed application form to:

**Head Office**

Independent Living Services  
2 Cooperage Way  
Alloa FK10 3LP  
Recruitment Hotline - 0800 055 6219  
Tel - 01259 226 300  
Fax - 01259 226 311

**Ayr Office**

Independent Living Services  
2 West Sanquhar Road  
Ayr KA8 9HP  
Recruitment Hotline - 0800 023 4256  
Tel - 01292 287 287  
Fax - 01292 611 144

**Ellon Office**

Independent Living Services  
13 The Square  
Ellon AB41 9JB  
Recruitment Hotline - 0800 121 4896  
Tel - 01358 723 630  
Fax - 01358 720 566

**Elgin Office**

Independent Living Services  
Park House Centre, South Street  
Elgin, Morayshire IV30 1JB  
Tel - 01343 548 090  
Fax - 01343 548 440

**Nurseplus Office**

Independent Living Services  
Glenruthven Mill, Abbey Road  
Auchterarder PH3 2DP  
Tel - 01764 663 004  
Fax - 01764 663 150

**nurseplus**

**Email -  
[info@ilsscotland.com](mailto:info@ilsscotland.com)**

**Website -  
[www.ilsscotland.com](http://www.ilsscotland.com)**

Offices at Ayr are  
Home Concern (Scotland) Ltd  
trading as Independent Living Services