

June 2023

EGM Healthcare Staffing S	olution Office: Manchester	
Address	1 Back Shakerley Rd, Tyldesley, Manchester M29	8RF, United Kingdom
Tel No.	+44 7766 383168	
Position applied for		
Individual's Details	T	
Title		
Surname		
Forenames		
Address		Photograph
	Postcode:	
Home Tel No.	Mobile No.	
Email Address		
National Insurance No.		
Next of Kin		
Name		



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Relationship					
Address					
	Postcode	:			
Tel No.					
Full employment record Use additional sheets if neces	d (most rece sary. Please	nt first) explain any gaps in e	mployment i.e. stud ^ဂ	ying, unemployment, ra	sing family etc.
Name and address of em	nployer	Start date mm/yy	Finish date mm/yy	Duties	Reason for leaving
Gaps in Er	mployment			Reason why	



June 2023

(most recent first)	Start and finish dates	Quai	ifications g	ained
		+		
urses and Training				
Subjects covered (most recent first)	Dates attended	Skills	relevant to	work
	·	-		
avel				
you have a driving licence?			○ Yes	O No



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References

Please give details of two senior individuals who may be approached for references. Where possible these should be your current and last employer and at least one must be from previous employment.

Current Employer if any			
Contact Name		Company	
Address	Postcode:		
Tel No.			
Email address			
Previous Employer			
Contact Name		Company	
Address	Postcode:		
Tel No.			
Email address		_	



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Criminal Record

EGM Healthcare Staffing Solutions is required under the Health & Social Care Act 2008, to obtain an Enhanced Disclosure and Barring Service check in relation to any person working with vulnerable adults and children. Therefore, if your application is successful, we will need to obtain this check before your appointment is confirmed.

Please advise EGM Healthcare Staffing Solutions of any criminal convictions (excluding minor road traffic offences), cautions, reprimands or warnings you have received before we obtain an Enhanced Disclosure and Barring Service check. Having a criminal record will not necessarily mean that you will not be able to work in the social care sector but will depend on the nature of the position, the circumstances and background of your offences.

Have you been convicted of a criminal offence or received a caution, warning or reprimand?		○ Ye	es	O No	
Date of conviction, caution, warning or reprimand	Details			Date	
				L	
Is your DBS registered with the DBS Update Serv	rice?		○ Yes	O No	
Do you give consent to EGM Healthcare Staffing certificate online?	Solutions to ch	neck your DBS	O Yes	O No	
Too	ماد ۵ اماد داد ماد	Jula			
Please tick each task in which you are experience	sk Ability Sche	iule			
Trease don each task in which you are experience					
Personal Hygiene		Nutrition			
☐ Bath/shower/strip wash		☐ Preparing meals			
☐ Bed bath		Feeding			
Use of bath aids		☐ Food handling			
Shaving		Food presentation			
Mouth care (inc. dentures)					
Care of hair		Administrative Abili	ties		
Care of feet (excl. toenails)		Report writing			
Care of fingernails Dressing/undressing		Recording instructions from GP/nurse Recording changes in client's condition			
Care of eyes		Recording changes in	client's condition		
Care or eyes		Practical Tasks			
Medication		Light housework			
Level 1 Prompt/Assist		☐ Washing personal laun	ıdrv		
Level 2 Administer		Shopping			
Level 3 Administer using specialist technique	s	Bed making/changing	a bed		



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Continence Management Continence care			nose and eardro	ops		Collect	ing benefits		
Bedpans/commodes etc. Older people Changing a catheter bag Physical disability Supporting clients with infectious diseases Mobility Mental health Learning disabilities Learning disabilities Supporting disabilities Children and young people Support with walking aids Other Uffing and moving of clients Monitoring Water temperature Fluid intake Other Drine output Bowel movements Working Times Regulations Declaration f you DO wish to work more than 48 hours per week, it is necessary to sign the form below to show that you are available. (name) Confirm that I want to be able to work more than 48 hours per week and that I will give you adequate notification in writing should I wish to reduce these hot to less than 48 hours. f you DO NOT wish to work more than 48 hours per week, it is necessary to sign the form below to show that you are not available f you DO NOT wish to work more than 48 hours per week, it is necessary to sign the form below to show that you are not available (name) Confirm that I do not want to work more than 48 hours week. f you DO NOT wish to work more than 48 hours per week, it is necessary to sign the form below to show that you are not available (name) Confirm that I do not want to work more than 48 hours week. (name) Confirm that I do not want to work more than 48 hours week. (name) Confirm that I do not want to work more than 48 hours week. (name) Confirm that I do not want to work more than 48 hours week. (name) Confirm that I do not want to work more than 48 hours week. (name) Confirm that I do not want to work more than 48 hours week. (name) Confirm that I do not want to work more than 48 hours week. (name) Confirm that I do not want to work more than 48 hours week. (name) Confirm that I do not want to work more than 48 hours week. (name) Confirm that I do not want to work more than 48 hours week. (name) Confirm that I do not want to wo	(Continence Man	agement						
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Stoma care Physical disability Supporting clients with infectious diseases Mobility Supporting clients with infectious diseases Mohit health Learning disabilities Children and young people Children and young		Bedpans/commod	es etc.				-		
Mobility Supporting clients with infectious diseases Mobility Mental health Learning disabilities Children and young people Other Other Other		☐ Changing a cathe	er bag			☐ Palliativ	e Care/ End of life		
Mobility Mental health Learning disabilities Learning disabilities Learning disabilities Learning disabilities Children and young people Children and young		Stoma care				☐ Physica	al disability		
Learning disabilities Learning disabilities Learning disabilities Learning disabilities Learning disabilities Children and young people Other Other						Suppor	ting clients with infe	ectious diseases	
Lifting and handling	ſ	Mobility				☐ Mental	health		
Support with walking aids Other		-	g			Learnin	ıg disabilities		
Monitoring Water temperature Fluid intake Working Times Regulations Declaration Bowel movements		Use of hoist (man	ual/electric)			☐ Childre	n and young people	e	
Lifting and moving of clients		Support with walk	ng aids			☐ Other			
Monitoring Water temperature Fluid intake Nutritional intake Urine output Bowel movements Working Times Regulations Declaration Morking Times Regulation Mo									
Working Times Regulations Declaration f you DO wish to work more than 48 hours per week, it is necessary to sign the form below to show that you are available. (name)		_							
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Urine output Bowel movements	_								
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Right to work in the UK

I (name) provide the corre	ct documents/ wo	con rk permits/ visas to	firm that I have the contraction of the contraction	ne right to wo	rk in the UK and	d can		
Signed			Date					
Applicant Declaration I declare that the information given on this application form is true and whilst I understand that all personal information about me which relates to my position with EGM Healthcare Staffing Solutions is confidential, I hereby give my permission for this information to be made available, on an 'as needs to know' basis, to and including the Regulatory Body and those authorised within the Local Authority. I hereby agree that I shall not disclose any confidential information to any third party unless I have written consent from EGM Healthcare Staffing Solutions. I understand that if any aspect of this declaration is false, or I disclose any confidential information, it is liable to lead to actions being taken and it may affect the offer of work being made to me. I certify that I have answered all questions truthfully and fully and will notify EGM Healthcare Staffing Solutions if there are any changes or updates to the information given.								
Print I	Name	Sig	ned		Dated			