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## APPLICANT PROFILE

Surname: \_\_\_\_\_

Previous surnames (if any): \_\_\_\_\_

Forename(s): \_\_\_\_\_

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

\_\_\_\_\_

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

Home Tel No: (inc STD code) \_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Mobile Tel No: \_\_\_\_\_

Nationality: \_\_\_\_\_

Licensed Car Driver: \_\_\_\_\_

Qualification(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

National Insurance Number: \_\_\_\_\_

National Insurance Category: Full/ Reduced/ Exempt (Office Use Only)

Name of Emergency Contact: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Home Tel No. (inc STD code): \_\_\_\_\_

(Essential)

Mobile Tel No. : \_\_\_\_\_

Work Tel No. (inc STD code): \_\_\_\_\_

**AVAILABILITY – when will you be available to work?**

Please complete this page to let us know when you may be available for working for Train2Care Academy and advise us of your previous experiences and tell us if there are any health issues that we need to be aware of.

**Hours of Work / Types of Shifts**

Full Time       Live in       Domiciliary   
Part Time       Nights       Residential

Please tick (✓) Days and Times available to work regularly

Availability:	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Morning							
Afternoon							
Evening							
Night							

**GENERAL INFORMATION**

Are you willing to work in Service Users homes or environments where there are smokers?  Yes  No  
(Please be aware that we operates a No Smoking policy)

Are you willing to work where there are domestic pets?  Yes  No

Are you willing to work more than 48 hours within a 7 day week?  Yes  No

## WORKING EXPERIENCE/KNOWLEDGE

- Have you completed the Common Induction Standards? (YES  / NO  )
- Do you have skills for Care/Common Inductions Standards 'signed off certificate'? (YES  / NO  )
- Have you achieved an NVQ in Care? (YES  NO  Other \_\_\_\_\_)

## WORKING EXPERIENCE CHECKLIST

Have you had training and/or experience of: Please tick (✓)

		No Experience	Experience	Trained
Personal Care	Dressing/undressing			
	Washing			
	Bathing			
	Bed baths			
	Bath aids			
	Use of bedpans/commodes			
	Hair care			
Specialist Care	Eye care			
	Pressure area care			
	Continence			
	Catheter bags			
	Mouth care			
	Colostomy care			
Mobility	Moving and handling			
	Use of hoists			
	Walking aids			
Nutrition	Meal preparation			
	Feeding			
	PEG Feeding			
Practical	Housework			
	Laundry / Washing			
	Bed making			
	Shopping			
Specialist	Palliative care			
	Dementia care			
	Learning disabilities			
	Physical disabilities			
	Child care			
	Mental health			
Other (Please specify)				

## DECLARATION OF HEALTH

Please note: you must inform your local office immediately if your health changes significantly.

Have you ever had?

Please tick (✓) the appropriate box.

Tuberculosis, asthma, bronchitis or chest complaints?  Yes  No  
If "Yes", Additional Information:

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Chest pain, heart condition or raised blood pressure?  Yes  No  
If "Yes", Additional Information:

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Blackouts, fits or attacks of giddiness?  Yes  No  
If "Yes", Additional Information:

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Depression, mental Health needs/problems?  Yes  No  
If "Yes", Additional Information:

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Rheumatism or arthritis?  Yes  No  
If "Yes", Additional Information:

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Back trouble?  Yes  No  
If "Yes", Additional Information:

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Typhoid, paratyphoid or dysentery?  Yes  No  
If "Yes", Additional Information:

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Digestive or bowel disorder?  Yes  No  
If "Yes", Additional Information:

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Diabetes, thyroid or other gland trouble?  Yes  No  
If "Yes", Additional Information:

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Bladder or kidney trouble?  Yes  No  
If "Yes", Additional Information:

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Dermatitis or skin trouble?  Yes  No  
If "Yes", Additional Information:

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Varicose veins?

Yes  No

If "Yes", Additional Information:

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Any other accident, operation or illness?

Yes  No

If "Yes", Additional Information:

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Have you any reason to believe you may be infected by any communicable disease?

Yes  No

If "Yes", Additional Information:

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Any other current or recent medical condition or treatment that may affect your attendance or performance at work?

Yes  No

If "Yes", Additional Information:

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Do you intend to work night duties on a regular basis?

Yes  No

If "Yes", Additional Information:

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Any illness/medical condition preventing you from working or performing your normal duties/activities for more than one week during the past year?

Yes  No

If "Yes", Additional Information:

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Any physical disabilities including defect of sight or hearing?

Yes  No

If "Yes", Additional Information:

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Do you have any allergies?

Yes  No

If "Yes", Additional Information:

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If the answer is **yes** to any of the questions in this section, please give further details in the space provided of the dates, duration and outcome of the illness or condition. If Train2Care Academy has concerns about your fitness to work, any offer of employment may be subject to a satisfactory medical report.

Have you received vaccination for any of the following?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Tuberculosis BCG                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rubella (German Measles)                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tetanus                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Flu                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis B                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Certificate of vaccination (Hepatitis B) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

It may be a requirement of any assignment that you have a Hepatitis B vaccination. Restrictions may apply if you do not have a current certificate of vaccination.

**I certify that I am fit for work in the care industry**

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

Designation/Post: \_\_\_\_\_

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

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

Office Use Only \_\_\_\_\_

**I certify that I am satisfied to the best of my knowledge that this employee is fit to undertake work in the care industry**

Manager/Interviewer: \_\_\_\_\_

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

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