



**CROWN** MEDICAL SERVICES LTD

## CLEANING EMPLOYMENT APPLICATION FORM

**Position Applied for:** \_\_\_\_\_

### Personal Details

Title:	Street Address:
First Name:	Address Line 2:
Middle Names:	Town:
Last Name:	Postcode:
Phone (Home)	National Insurance Number:
Phone (Mobile):	Passport Number:
Email Address:	Date of Birth:
Are you free to remain and take up employment in the UK?	
Visa Number:	Date of Expiry:

### Next of kin/Emergency contact details

Name (Miss/Ms/Mrs/Mr/Dr):	Surname:
Street Address:	
Phone (Home):	Phone (Mobile):

## Convictions/Disqualifications

In view of the nature of the work for which you are applying, the post is considered to be exempt from the provisions of the Rehabilitation of Offenders Act 1974 as contained within the Exceptions Amendment Order 1986. Applicants are required to give details of all convictions for criminal offences, including pending convictions and those which would otherwise be considered "spent". Failure to provide details of convictions could result in dismissal or disciplinary action. If there are no convictions, please state "none".

Having a criminal record will not necessarily bar you from working with us. Crown Medical Services Ltd complies fully with the DBS Code of Practice regarding the correct handling, use, storage retention and disposal of Disclosures and Disclosure information. We make every subject of a DBS Check aware of the existence of the DBS Code of Practice and make a copy available on request

**Do you have any Spent or Unspent Convictions: Yes      No**

**If yes please state:**

I confirm that to the best of my knowledge, the details contained above are correct.

**Signature: .....**      **Date:.....**

## Disclosure and Barring Service (DBS) Check

I authorise Crown Medical Services Ltd to carry out a DBS check on my behalf as and when required. Understand that before I can commence work with Crown Medical Services Ltd. I need to have completed a DBS check.

**Signature: .....**      **Date: .....**

## Bank/Building Society Details

Account Holders Name:

Bank Name:

Account Number:

Sort Code:

I authorise **Crown Medical Services Ltd** to pay my weekly earnings directly into the bank or building society whose details I have given above. I confirm that I will notify **Crown Medical Services Ltd** in writing of any changes of these details:

**Signature: .....**      **Date: .....**

## Employment History

Please give details of your employment over the last 10 years commencing with your most recent job and including any agencies worked for. Where applicable, please explain any breaks in employment history. Continue on a separate page if necessary

Date from (MM/YY)	Date To (MM/YY)	Name & Address of Employer	Position Held (Duties)	Reason for leaving

**Education/Qualifications** (Training e.g. Professional cleaning, etc. (please provide certificates))

Date from (MM/YY)	Date To (MM/YY)	Course	Name & Address of University/College /Institute	Qualifications/Level

**Professional Referees**

Please provide at least two referees who would give reference on your character, work experience and suitability for the post applied for, Referees must be in a senior position to you. Please be aware that we are unable to offer you work until satisfactory references have been obtained. Please also note we are required to obtain references for you on an annual basis.

**Verified by:**

**Verified by:**

Name		Name	
Position held by referee		Position held by referee	
Company		Company	
Address		Address	
Work Telephone		Work Telephone	
Work Email		Work Email	

I hereby give Crown Medical Services Ltd permission to approach my referees at this stage for employment references and understand that Crown Medical Services Ltd reserve the rights to withdraw my application if my references do not meet a satisfactory level for healthcare staffing.

Yes  No

Your Availability for work							
How many hours would you like to work each week?				Hours			
Which areas would you be able to work in?				Please List			
Please indicate the times and days you would be available for work.							
	MON	TUE	WED	THU	FRI	SAT	SUN
Early Shift							
Late Shift							
Long – day							
Night Shift							
Are you a car driver?	Yes			No			
If you intend to use your car For Business, do you have the Required insurance cover?	Yes			No			
If yes, you will be required to produce both your driving licence and motor insurance certificates.							
Do you have any other work Commitments which may impair your ability to carry out your duties for Crown Medical Services Limited?	Yes (Please give details)			No			

EQUAL OPPORTUNITIES MONITORING							
Nationality							
Languages Spoken							
Age group (please indicate)	16-20		21 - 35		31 - 50		50+
Disabilities (please indicate)	Registered disability			Unregistered disability		No disability	
Ethnicity (please indicate which Best describes your ethnic origin)	White European			African		White British	
	Black Caribbean			Bangladeshi		Asian	
	Indian/Pakistani			Black British		Others	
How did you hear about this Post?							
Are you related to or do you know any Crown Medical Services Limited?							

## Declaration

I, the undersigned applicant, hereby declare that the information I have given in this application form is true to the best of my knowledge and belief. I consent to my personal data and CV being forwarded to clients. I consent to references being passed onto potential employers.

I agree that if I have given any false or misleading information, or do not give relevant information now or in the future, this may result in termination of an assignment without notice.

If, during the course of a temporary assignment, the Client wishes to employ me direct, I acknowledge that Crown Medical Services Ltd will be entitled either to charge the client an introduction/transfer fee, or to agree an extension of the hiring period with the Client (after which I may be employed by the Client without further charge being applicable to the Client).

**Yes**      **No**            **if no please state:**

## Confidentiality Agreement

During the course of your employment you may have access to see or hear information of a confidential nature. You are required not to disclose any information, particularly relating to client/ patient details, medical notes etc., to any unauthorised persons. You are reminded that any breach of confidentiality may result in disciplinary action or dismissal.

**Yes**     **No**

## Third Party Declaration

I hereby allow any information relating to my registration with Crown Medical Services LTD to be shared with relevant third parties. This will be overseen by the governance lead for Crown Medical Services Ltd

**Yes**      **No**            **if no please state:**

## Working Times Regulations

The Working Times regulations 1998 ("The Regulations") require Crown Medical Services LTD ("The Company") to limit your average weekly working time to 48 hours unless you agree with The Company that the limit shall not apply to you. The Company wished to have an agreement with you. It proposes an agreement (which will apply until terminated by notice) on the basis that:

1. The 48-hour limit on average weekly time will not apply to you.
2. You may terminate the agreement (so that the 48 hour time limit would apply to you) by giving the person at The Company to whom you usually report 4 weeks' written notice. Under the Regulations, The Company must keep records relating to your working time. This is the case whether or not you reach an agreement with The Company about waiving working time limits

**Yes**     **No**             **if no please state:**

## Agreement to opt out working times Regulations 1998

The Working Time Regulations 1998 provide that the average working week, including overtime, shall not exceed 48 hours. The Company and the Worker agree that this limit shall not apply to the Worker. This Agreement will remain in force indefinitely. The Worker, or the I Company, may terminate this Agreement at any time by giving not less than three months' written notice to the other.

**Yes**     **No**             **if no please state:**

## Declarations

I agree to inform Crown Medical Services Ltd Immediately if I am the subject of any pending Prosecution, work related investigation, Disciplinary action /professional misconduct. Also any changes to my personal circumstances that could affect my fitness to practise as a healthcare professional.

Yes  No  if no please state:

I give Crown Medical Services Ltd Permission to carry out all relevant Employment checks necessary for my registration including any external bodies.

Yes  No  if no please state:

I confirm that I am aware that the trust organisation where I attend assignments have the right to carry out any physical searches of me, my possessions and my vehicle while on the premises. All security checks must comply with the Human Rights Act 1998.

Yes  No  if no please state:

By signing this document you are confirming all the above agreements and also all the company's proposals.

This document will then be a record of agreement.

**Please sign below.**

**Signature:** .....

**Date:** .....