

## Healthcare Assistant Application

### Thank you for your enquiry about working with Cpl Healthcare

Cpl Healthcare incorporating Servisource Healthcare place Healthcare Assistants in hospitals and Healthcare organisations throughout Ireland, covering long-term, medium and short-term positions. Our company's policy is to provide a consistent and quality service by matching the individual needs of both our Care Staff and our Hospital Clients. Our office is open 7 days a week from 7am to 9.30pm, 363 days of the year to provide the best possible service.

Please fill in the relevant details in the application pack and send it back to us with as much information as you can provide immediately.

A checklist of requirements is on the following page to assist you. **Please be aware that all references and qualifications will be checked.**

Please sign and date the application and return it to our offices at:

**Cpl / Servisource Healthcare**, 2nd Floor, 49 St Stephens Green East, Dublin 2

**Cpl / Servisource Healthcare**, 10/11 Steamboat Quay, Dock Road, Co. Limerick

**Cpl / Servisource Healthcare**, Block 3, Quayside Business Park, Mill Street, Dundalk, Louth

**Cpl / Servisource Healthcare**, 4 Bruach Na Laoi, Union Quay, Cork

**Cpl / Servisource Healthcare**, 16a Sandyford Business Centre, Bohermore, Galway

In the meantime, if you have any queries regarding any aspect of our registration process, please a member of our Recruitment Department on **0818 365 100**.

Once again, thank you for your enquiry and we look forward to receiving your application in the near future.

Kind Regards

**Cpl incorporating Servisource Healthcare**

## Healthcare Assistant Application

**The following documentation is required to be returned with your signed application form:**

- Copy of passport
- One passport photograph (please sign the back of your photograph)
- Copy of Work Visa or Work Authorisation (Non-EU residents only)
- Copy of Garda National Immigration Bureau Card (Non-EU residents only)
- Moving and Handling Certificate
- CPR Certificate
- Infection Control Certificate
- Non Violent Crisis Intervention Certificate
- Elder Abuse Certificate
- Full Occupational Health Report
- Completed Garda Vetting Form
- €10 Postal Order / Cheque for Garda Vetting to be made out to Cpl Healthcare
- Curriculum Vitae
- FETAC Level 5 in Healthcare Support

## Personal Details

### Healthcare Assistant Application

First Name:		<b><u>ATTACH SIGNED</u></b>  <b><u>PASSPORT</u></b>  <b><u>PHOTOS</u></b>
Surname:		
Previous Name:		
Address		
Mobile No.		
Home No.		
Work No.		
Email Address		
Gender		
Date of Birth		
PPS Number		
Next of Kin		

Do you hold a Garda National Immigration Bureau card?	Yes	No
If Yes please state stamp number and expiry date		
Please state start and end date of permit/visa	Start date: __ / __ / ____                      End date: __ / __ / ____	

How did you hear about our Agency?	Newspaper	Nursing Magazines	Internet	Friends	Other

Preferred Healthcare Organisations you wish to work in	
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### Education/Qualifications

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Second Level Education	
Address & Telephone Number	
Dates of Attendance	

Have you completed or are you in the process of completing a FETAC Healthcare Support Major Award?	Yes	No
If Yes, Name of Modules and Dates attended		
Copy of Certificate enclosed?	Yes	No

Are you a Student Nurse?	Yes	No
What discipline are you studying?		
If Yes, Name of Training Hospital		

Have you completed a Pre Nursing Course?	Yes	No
If Yes, Name of Course and Dates attended		
Copy of Certificate enclosed?	Yes	No

Have you completed a Health Care Assistant Course?	Yes	No
If Yes, Name of Course and Dates attended		
Copy of Certificate enclosed?	Yes	No

## Healthcare Assistant Application

### Training

Date of last Patient Moving and Handling Course		
Issuing Body		
Copy of Certificate Enclosed	Yes	No
Date of last CPR Course		
Copy of Certificate Enclosed	Yes	No
Date of last Non Violent Crisis Intervention Course / CPI Training		
Copy of Certificate Enclosed	Yes	No
Date of last Elder Abuse Training?		
Copy of Certificate Enclosed	Yes	No
Date of last Infection Control Course		
Copy of Certificate Enclosed	Yes	No

## Healthcare Assistant Application

### **Employment History & References**

- We require names and contact details of your **3 referees** from your current and most recent employment.
- Referees must be of CNM 1 level or higher.
- One reference must be from your current or most recent employer
- Any offers of a post is subject to satisfactory references

### **Current / Most Recent Employment**

Healthcare Organisation		
Location		
Ward		Position Held
Date	To:	From:
Months in Post		
<b>(1<sup>st</sup>)</b> Referee's Name From Current Position or Most Recent Employment		
Referee's Position		
Referees Contact Details Phone/ Fax / Email		

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### Previous Employment:

Healthcare Organisation		
Location		
Ward		Position Held
Date	To:	From:
Months in Post		
<b>(2nd)</b> Referee's Name		
Referee's Position		
Referees Contact Details Phone/ Fax / Email		

Healthcare Organisation		
Location		
Ward		Position Held
Date	To:	From:
<b>(3rd)</b> Referee's Name		
Referee's Position		
Referees Contact Details Phone/ Fax / Email		

**Please continue your experience and employment on a separate Curriculum Vitae**

## Healthcare Assistant Application

### **Personal Pay Details**

Please fill in the following information carefully and return it with your application form

First Name	
Surname	
Address	
Mobile Phone Number	
Home Phone Number	
Email Address	
Date of Birth	
Staff Type	Health Care Assistant
Bank Name	
Bank Address	
Account Number (8 numbers)	
Bank Sort Code (6 numbers)	
PPS Number	

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### Health Declaration

I declare that I understand, accept and confirm the entitlement of Cpl Healthcare incorporating Servisource Healthcare (the agency) to reject my application or terminate my employment (in the event of a contract of employment having been entered into) where I have omitted to furnish the Agency with any information relevant to this health assessment or where I have made any false statement or misrepresentation relevant to this health assessment.

Please answer YES or NO and if YES, please give details in the space provided.

		Yes	No	Details
1	Do you have, or have you ever had, any medical conditions or surgery in the past 5 years?			
2	Are you at present attending a doctor for medical care, taking any medication or on a waiting list for hospital assessment or treatment?			
3	Have you ever suffered a work related illness, or given up work due to ill health?			
4	Do you have impairment / disability (physical or mental) or specific learning disability which may affect your ability to work?			
5	Have you ever suffered from tuberculosis (TB)? Within the past 12 months			
	Has any family member or close contact been treated for TB?			
	Have you had a cough for more than 3 weeks?			
	Have you coughed up blood?			
	Have you had any unexplained weight loss?			
	Have you suffered from night sweats or fever?			
6	Have you ever had any kind of back, joint or muscle problem?			
7	Have you ever had: Dermatitis, Eczema, Psoriasis or any other skin condition?			
8	Have you ever had any mental illness which might affect your ability to work? (including anxiety, depression, self-harm, eating disorders, psychological or emotional problems)			
9	Have you ever had a drug or alcohol problem?			

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10	Do you have any difficulty with your eyesight (including colour blindness)?			
11	Do you have difficulty with your ears or hearing?			
12	Have you ever suffered from any of the following; loss of consciousness including fainting attacks, blackouts, dizziness, epilepsy?			
13	Have you ever suffered from any of the following; heart disease or circulatory problem; including high blood pressure, varicose veins			
14	Have you ever suffered with chest or lung problems; Asthma, Bronchitis?			
15	Have you any allergies; including allergies to drugs, food or latex?			
16	Have you ever received treatment for bowel or gastric problems?			
17	Have you ever suffered a disorder of the bladder or kidneys?			
18	Do you have any other medical condition not previously mentioned in questions 1 – 17 above?			

Previous Sickness Absence – time lost from work due to illness over last 2 years.

Length of absence	Reason for absence

<b>GP Name</b>	
<b>GP Address</b>	
<b>GP Telephone</b>	

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

**Print Name:** \_\_\_\_\_

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

## Healthcare Assistant Application

### Declaration

#### I agree to the following:

- I confirm that the information given on this form application form is complete and correct.
- I agree to Cpl Healthcare incorporating Servisource Healthcare terms and conditions of employment.
- Cpl Healthcare incorporating Servisource Healthcare is authorised to acquire any information sought concerning the application and regarding my work character or skills and that this information may be forwarded to potential employers.
- I agree to treat as confidential any information received concerning the business of Cpl Healthcare incorporating Servisource Healthcare or its clients.
- Cpl Healthcare incorporating Servisource Healthcare will not be liable for professional negligence, errors, omissions, or accidents whilst you are under the hirer's custody or control.

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

**Print Name:** \_\_\_\_\_

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

## Healthcare Assistant Application

### Working Time Regulations

The European Union has laid down guidelines for all workers governing the length of the maximum working week, which it is deemed safe to work. The current limit is a maximum average net weekly working time of 48 hours per week over a period of 16 weeks.

Copy of Working Time Regulation Act is available to you upon request.

I confirm that I have read and understand the information regarding the working time regulations and it is my responsibility to adhere to same.

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

**Print Name:** \_\_\_\_\_

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

### Hand washing technique declaration

Hand washing is the single most important procedure in the implementation of infection control.

It is essential to wash hands frequently and correctly.

All employees of Cpl Healthcare incorporating Servisource Healthcare are obliged to follow hand washing procedures whilst on duty, according to attached hand washing technique.

I confirm I have and read understand the information regarding hand washing procedures and will adhere to this technique whilst on duty for Cpl Healthcare incorporating Servisource Healthcare.

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

**Print Name:** \_\_\_\_\_

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

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### **Criminal Declaration**

*Please note this Criminal Declaration must be witnessed by either:*

- *Commissioner of Oath*
- *Solicitor*
- *Garda Siochana*

**I, (NAME)** \_\_\_\_\_

**of (ADDRESS)** \_\_\_\_\_

### **HEREBY DECLARE that:**

I have never been arrested for or convicted of any offence or crime (other than an offence under road traffic legislation), either in Ireland or in any other state;

I have never been the subject of a pardon or amnesty or other similar legal action in respect of any offence or crime (other than an offence under road traffic legislation for which a penalty of imprisonment is not enforceable);

I have never unlawfully distributed or sold a controlled substance (drug);

I am not currently nor have I ever been under investigation by the Garda Siochana police force of any state in relation to the commission of a crime (other than an offence under road traffic legislation for which a penalty of imprisonment is not enforceable);

I am not currently nor have I ever been the subject of disciplinary action by any professional or statutory body with responsibility for regulation of the nursing or medical professions.

I hereby authorise each of the Dublin Academic Teaching Hospitals and/or its relevant health board to make enquiries, for the purpose of verifying any part of this declaration, with An Garda Siochana and/or with the regulatory body of the nursing or medical professions of any state. This data will be processed by the Hospital and the Agency in accordance with the Data Protection Acts, 1988 and 2003.

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

Witnessed by: \_\_\_\_\_ Date \_\_\_\_\_

Official Stamp:

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**VACCINATION / IMMUNE STATUS HISTORY**

*To be completed and stamped by an Occupational Health Professional / General Practitioner.*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The above person has the following vaccinations carried out.

Hepatitis B                      1<sup>ST</sup> Date: \_\_\_\_\_      2<sup>nd</sup> Date \_\_\_\_\_      3<sup>rd</sup> Date: \_\_\_\_\_

Hepatitis B Titre              Date: \_\_\_\_\_                      Result: \_\_\_\_\_ mIU/ml

Hepatitis B Booster          Date: \_\_\_\_\_

Hepatitis B Titre              Date: \_\_\_\_\_                      Result: \_\_\_\_\_ mIU/ml

Measles (Serology)          Date: \_\_\_\_\_                      Result: \_\_\_\_\_

Mumps (Serology)            Date: \_\_\_\_\_                      Result: \_\_\_\_\_

Rubella (Serology)          Date: \_\_\_\_\_                      Result: \_\_\_\_\_

Varicella (Serology)         Date: \_\_\_\_\_                      Result: \_\_\_\_\_

Hepatitis C (Serology)      Date: \_\_\_\_\_                      Result: \_\_\_\_\_

Mantoux Test 2TU             Date: \_\_\_\_\_                      Result: \_\_\_\_\_

Mantoux Test 10TU          Date: \_\_\_\_\_                      Result: \_\_\_\_\_

BCG Scar Check                Date: \_\_\_\_\_                      Location: \_\_\_\_\_

Completed by:

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

Title: \_\_\_\_\_

Facility: \_\_\_\_\_

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

OFFICIAL STAMP:

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**Exposure Prone Procedures (EPP)**

**Do you undertake Exposure Prone Procedures:**                      **Yes**                       **No**

If **YES** the occupational health checks below must be completed out by a Medical Practitioner.

Tests must be carried out on identified validated samples (IVS). Only results from an Irish or UK occupational health service that has confirmed the identity of the person by checking appropriate photographic ID e.g. passport, driving licence or a photographic ID card will be accepted. For International recruitment, please refer to International recruitment documentation.

Specific requirements of Health Care Workers performing Exposure Prone Procedures

Hepatitis B antibody (Anti-HBs)	Date checked: _____	Result: _____
Hepatitis B core antibody (Anti-HBc)	Date checked: _____	Result: _____
Hepatitis B surface antigen (HBsAG)	Date checked: _____	Result: _____
Hepatitis Be antigen (HBeAG) <i>(If Hepatitis B surface antigen test is positive)</i>	Date checked: _____	Result: _____
Hepatitis B viral load <i>(If Hepatitis B surface antigen / Hepatitis Be antigen test is positive)</i>	Date checked: _____	Result: _____
Hepatitis C antibody	Date checked: _____	Result: _____
Hepatitis C virus RNA <i>(If Hepatitis C antibody test is positive)</i>	Date checked: _____	Result: _____

**Completed by:**

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

Title: \_\_\_\_\_

Facility: \_\_\_\_\_

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

OFFICIAL STAMP:

## Healthcare Assistant Application

### Garda Vetting Form

Cpl Healthcare incorporating Servisource Healthcare is now seeking Garda Vetting for all applicants on behalf of our clients. This is an important document that needs to be completed as instructed below.

We need you to complete and return the form to us at **2<sup>nd</sup> Floor 49 St Stephens Green Dublin 2**

Please ensure when completing the Garda form that you have all the following details:

- Full name (and any previous names)
  - Addresses– if you are unsure of the full address then please enter in any of the address information you do know e.g.: if you do not know the number of the house you I lived in but know the street name and town then please state the address with the information you have. Please do not leave any boxes empty and write 'unknown' in the areas that you are unsure of. Please list all addresses since birth including any from overseas.
  - Ensure the overleaf of the application is signed and dated. Please write your name in block capitals underneath your signature.
  - Please write legibly in **black pen** and send the completed form back with your application along with €10 Postal Order / Cheque.
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Upon successful completion of this application form your Cpl Healthcare / Servisource Healthcare Recruitment Consultant will arrange to meet you.

Once again thank you for taking the time to compete this application form and we look forward to working with you in the near future.

Kind regards,



**Elaine Higgins**

**Manager**