FlexiCoventry Limited
110 ash Green Lane
Coventry CV7 9AJ
Office Hrs Tel: 02476 360078
E-mail: info@flexicoventry.co.uk
Web: www.flexicoventry.co.uk

Application Form

Please use blank ink to fill in this application form.
Please use BLOCK CAPITALS

Post Applied For:

Current CRB No. :

Personal Details

Title (E.g. Mr/Miss/Mrs/Ms:

Surname: Forenames:

Previous names:

Address:

Post Code:

Mobile No. : Tel No:

Date of Birth:
N. I No:

Next of Kin: Relationship:

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Next of Kin Tel:

Next of Kin Address:

EMPLOYMENT

(Please list for the last 10 years, do not leave gaps in the dates and explain any periods of non employment. Continue on a separate sheet if necessary)

Present Employer and address	Position Held	Reason for leaving	Dates
Previous Employers and addresses	Positions Held	Reason for leaving	Dates

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Previous Employers and addresses	Positions Held	Reason for leaving	Dates

Education and Training

Name & Address of School	Subjects Studied	Results	Dates

Further Education

Name & Address of College University or Training Establishment	Subjects Studied	Results	Dates

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Please list any additional/On job training (e.g. manual handling, CPR etc.) Please enclose copies of any certificates relating to your qualifications or training.

Type __________ Date

Type __________ Date

FURTHER DETAILS

Please give any details that you feel may be relevant to your application together with any hobbies, experience, training and other interests that you may have.

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Immunisation Record

Please give details of two referees. One must be your last employer where you had employment for at least 3 months or at least from a previous employer.

Name & Job Title: ____________________

Organisation: ____________________

Address: ____________________

____

____

Post Code: ____________________
Email address____________________
Telephone Number: ____________________

Name & Job Title: ____________________

Organisation: ____________________

Address: ____________________

____

____

Post Code: ____________________
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Do you hold a full UK driving licence? Please circle as appropriate	Yes	No
Do you have access to use of a car?	Yes	No

FMA Limited is committed to equal opportunities and will not discriminate against anyone on their gender, race, creed, religion, disability, age, sexuality or marital status.
Under the Care Quality Commission we are obliged to carry out an enhanced check on all applicants with the Criminal Records Bureau. To do this we need to establish your identity. If you are asked to attend an interview you will be required to bring with you two passport size photographs and proof of identity. We will not be able to complete any application without the required information. If you are not a British Citizen you will also need to bring with you, documents which prove that you are entitled to work in this country.

The Rehabilitation of Offenders Act 1974 (Exceptions) (Amendments) Order 1986 requires that you must disclose details of any criminal convictions even if these are considered 'spent.'

You must also disclose if, you have been cautioned by a constable and which, at the time of the caution you admitted to it.

Do you have any criminal convictions or circle as Cautions to declare	Yes	No	Please appropriate

If yes please give details below.

DECLARATION

I certify that the information given is, to the best of my knowledge, is a true record and I understand that any offer of employment will be subject to the organisation being satisfied

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as to my state of health and references. If any information given in this form or by me in support of this application is not true, or that I have failed to disclose a criminal conviction, I recognise that any offer of a contract with the company will be terminated.

Signed______________________________________ Date ________________________

Flexicoventry Ltd

EXCELLENCE THROUGH EXPERIENCE

CONFIDENTIAL HEALTH DECLARATION

Name:			
Date of birth:	Sex:	Height:	Weight:
Doctors Name:			
Doctors Address:			
Doctors Telephone Number:			
Please give the date of your last medical examination :			
Please give the date of your last dental examination:			

In the last 5 years have you attended hospital as either an in patient or out patient? If yes please give details:	**Yes**	**N0**
Have you ever been refused or left employment for health reasons?		

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If yes please give details:		
Have you ever been refused insurance for health reasons? If yes please give details:		
Are you currently receiving medical treatment? If yes please give details:		
Are you currently taking any medication? If yes please give details:		

Have you currently or previously had any problems with the following:	**Yes**	**No**
1) Anxiety/Mental health problems?		
2) Excessive weight gain or loss?		
3) Migraine/ severe headaches or neck pain?		
4) Asthma or hay fever?		
5) Chest infections/conditions?		
6) Bladder or kidney problems?		
7) Heart or circulation problems?		
8) Blood pressure problems?		
9) Varicose veins?		
10) Back problems including any conditions that have caused absence from work?		
11) Diabetes?		
12) Fainting/Epilepsy/blackouts?		
13) Thyroid or other glandular illness?		
14) Skin disorders?		
15) Ears or eyes		
16) Blood disorders/jaundice		
17) Rheumatism or arthritis		
Have you ever had any of the following diseases?		
18) Chicken Pox		
19) Hepatitis A, B or C		
20) Typhoid		
21) Tuberculosis		
22) Food Poisoning		

If yes to any of the above please give details in the box below put the number of the Question beside the relevant details.

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Please give immunisation/vaccination details		Date
1. Tuberculosis (BCG) (Evidence will be needed regarding TB immunity)		
2. Rubella (German measles)		
3. Poliomyelitis		
4. Tetanus		
5. Hepatitis B	Date needed for primary course one	
Hepatitis B	Date needed for primary course two	
Hepatitis B	Date needed for primary course three	
Please note that an immunisation certificate will be needed.		

If you have lived outside the UK for any period of time within the last five years please give details of place of residence and dates you arrived and left.

Place of residence	**Date arrived**	**Date Left**

General Questions	**Yes**	**No**	**Further details**	**Answer**
Do you smoke?			If yes how many per week?	
Do you drink?			If yes how many unit per week?	
Have you lost time from work due to illness?			If so how many days have you lost In total in the last two years?	

I declare that the above information is correct to the best of my knowledge. I understand that if further information is needed from my GP, I will be asked to give my consent. I also understand that if any information including my health changes it is my responsibility to inform you immediately.

Signature……………………………………. Date…………………………

Print Name………………………………………………………………………

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