**Application Pack Content**

Below are the required document to make you complaint to start work with ANK Solutions Ltd

1. Application pack
2. CV covering 10 year no gap

3 DBS (We must be able to perform an online update check

4. Immunisations

5. Mandatory Training – Completed within the past 12 months

6. NI card / Letter

7. Qualifications

8. Passport or Right to work in the UK

9. Photo (for ID Badge)

10. Two proofs of Address (Colour copy of driver’s licence /council tax letter/bank statement/utility Bill

11. X 2 References from previous workplace

We are glad to welcome you to ANK Solutions Ltd ; we look forward to working with you. We have made it easy to complete, you can send all your documents via WhatsApp on 07940538775 and email to [info@anksolutionsltd.com](mailto:info@anksolutionsltd.com) or send it through post to the office address above.

If you have any queries, please don’t forget to contact us.

Kinds regards

Compliance Team.

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| Section 1- PERSONAL INFORMATION | | |
| *Please attach a photograph of yourself here* | Title (Mr, Mrs, Ms, Dr, etc.): |  |
| First/middle name: |  |
| Surname: |  |
| Primary Tel No.: |  |
| Secondary Tel No.: |  |
| Email Address: |  |
| National Insurance Number: |  |
| Address: |  | |
| Postcode: |  | |
| Video call details: | Skype:  FaceTime:  Other: Zoom | |
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| Section 3- POSITION APPLIED FOR | | | | | |
|  | | | | | |
| CAREWORK | | | | | |
| Home Care |  | Live-in Carer |  | Hospital HCA |  |
| Support Worker |  | Residential |  | Other (Please specify below |  |
|  |  |  |  |  |  |
| HEALTHCARE PROFESSIONAL | | | | | |
| Mental Health Nurses |  | Qualified Nurse |  | Midwife/Health visitor |  |
| Health Care Assistant |  | AHP |  | Other (Please specify below) |  |
|  |  | Non-medical/ Nonclinical |  |  |  |

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| Section 2 – NEXT OF KIN | | |
| Surname: | First name: |  |
| Address: | Tel No: |  |
| Mobile No: |  |
| Emergency Contact No: |  |
| Relationship to you: |  |
| Postcode: |

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| Section 4- POSITION APPLIED FOR | | | | | | | | | | | | | | | | | | |
| (NMC)/GMC/HCPC Number: |  |  |  |  |  |  |  |  |  | Expiry Date: |  |  |  |  |  |  |  |  |
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| Section 5: PASSPORT/VISA DETAILS | | | |
| Passport Nationality: |  | Passport expiry date: |  |
| Type of Visa/ Work Permit held (e.g. Student Visa Tier 2) |  | Visa/Work permit expiry date: |  |
| Visa Restrictions (if applicable) |  | | |

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| Section 6 -EMPLOYMENT HISTORY  (*Please declare 10 years in reverse order including any gaps)* | | | | | |
| Date (MM/YY)  From To | | Name, Address & Tel no. Of Employer | Job Title & Specialities covered | Reasons for leaving |
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| Section 7-EDUCATION HISTORY | | | | |
| School/College/University | Address | From MM/YY | To  MM/YY | Qualifications gained |
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| Section 8 Marketing |  |  |  | |  | |
| How did you hear about us? | | | If recommended by an employee, please specify their name; | | | |
| Referrals | | | | | | |
| Name & relationship to you: | Tel Number: | Email address: | | Speciality | | Post code |
| Name & relationship to you: | Tel Number: | Email address: | | Speciality | | Post code |
| Name & relationship to you: | Tel Number: | Email address: | | Speciality | | Post code |

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| Section 9- PROFESSIONAL REFERENCES  (*One reference must be your current employer and both references need to cover the last 3 years)* | | |
|  | 1st reference | 2nd reference |
| Name of Referee: |  |  |
| Address:  (Business Address) |  |  |
| Postcode; |  |  |
| Position held: |  |  |
| Referee’s email address (this is a mandatory requirement) |  |  |
| Telephone No.: |  |  |

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| Section 10 -PAY | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Account holder name: | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Bank Building society name: | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Bank/ Building society address: | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Role number for automated BACS payments (Building society only) | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Sort code: |  |  |  | |  | |  | |  |  |  |  | | Account number: | | | | |  |  |  |  |  |  |  |  |  |
| FOR LTD COMPANY WORKERS | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LTD Company name: |  | | | | | | | | | | | | | Registration No: | | | | |  | | | | | | | | |
| LTD Company address: |  | | | | | | | | | | | | |  | | | | |  |  |  |  |  |  |  |  |  |
| Is your LTD Company registered via an umbrella company (e.g. ISS) if so, please give details below | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| SELF EMPLOYED | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| UTR Number: | | | |  | |  | |  | |  |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Section 1- Declaration |
| You are required by ANK Solutions, to sign the below, declaration form, at the stage of the registration process, in order to confirm the following: |
| Confidentiality |
| * While you remain an employee of ANK Solutions, you will have access to Confidential Information about patients and clients. On no circumstance or account must any information relating to either party be divulged to anytime other than your Branch Manager or Consultant. * You Should not under any circumstances discuss any information with parties outside of your working organisation either your Family members. friends, neighbours. If you have received any information you consider needs to be addressed please call consultant and ask for private meeting. Failure to observe these rules Will be regarded as serious misconduct which may result in removal from the agency register |
| Disqualification from Caring for Children (England) Regulations 2002 Declaration |
| By Virtue Of section 6S of the Children Act 1989, as amended by the Care Standards Act 2m a person who is disqualified from fostering a child privately is also disqualified from carrying on being concerned in the management of, having any financial interest in, a children’s home, and may not be employed in children's home, with the consent of the relevant local authority.   * Section 6S (4) of the Children Act 1989 provides that a person who falls to disclose to the registration authority that she/he is disqualified from carrying on, being concerned in the management of, or have a financial interest In a Children's Home (or does those things Without the consent of the resignation authority) shall be guilty of Offence and liable on summary conviction to imprisonment not exceeding six months or to a fine. * By this form you certify that you declare no child you are a parent of has been made the subject Of a Care Order at any time, or has been removed from your Care by a court order Other than a custody or court order in favour of the child's other parent. You have never been convicted of an offence involving a child, had your registration in respect of a children's home cancelled, have not carried on, was otherwise concerned with management of, or had any financial interest in a voluntary home or a children's home where the registration was cancelled. |
| Rehabilitation of Offenders Act 1974 |
| By Virtue of the Rehabilitation Act 1974 (Exemption) (amendments) Order 1986, the provisions Of section 4.2 Of the Rehabilitation of Offenders Act 1974 do Not apply to any employment which is concerned with the provision of health Services and which is Of such a kind as to enable the holder to have access to persons in receipt Of such services in the course of his/her normal duties. Your answers to the following questions may not affect your application.  **Do you have convictions, cautions, reprimands or final warnings, that are not "protected", as defined by the Rehabilitation of offenders Act 1974 (Exceptions) Order 1975 amended in 2013) by Si 2013 1198? Yes / No**  **If yes, please provide us with the details**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Note: any conviction may need to be declared to the client at any stage*  **Do you hold a DBS that has been issued in the last 12 months**? Yes / No  In order for to process your application we need to obtain references from your previous employers or College/university that covers the last 3 years.  **Is your DBS registered with the Updated Service? Yes / No**  By signing this declaration form, it shows you give permission for ANK SolutionsLtd, for an updated Disclosure Barring Service (DBS) or complete an online check a DBS registered with the update Service when necessary. |
| References |
| In order for to process your application we need to obtain references from your previous employers or College/university that covers the last 3 years.  **Do you give permission for us to obtain these references on your behalf? Yes / No** |

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| Professional Registration |
| 1) That you are fully aware, that you must notify Healthcare professionals recruitment services about any changes/ concerns, with regard to your fitness to practice/ professional registration, with immediate effect. Note: Healthcare Professionals, failing to disclose any changes/ concerns, with regard to their professional registration, will be withdrawn, from work placements provided, by ANK Solutions Ltd with immediate effect, until evidence Of effective registration has been acquired/ full investigation has been completed, with a possible referral to the professional Regulatory Body. 2) That you have a current, effective professional registration, in order to practice in line with the professional Regulatory Body / Government guidelines and obligations as a healthcare professional. Note: Healthcare professionals, failing to maintain, their professional registration, will be withdrawn, from work placements provided, by ANK Solutions Ltd with immediate effect, until evidence of effective registration has been acquired/ full investigation has been completed, with a possible referral to the Professional Regulatory Body. 3) As per Professional Regulatory Bodies regulations, It is now mandatory that you have an appropriate indemnity arrangement in place. Having a professional indemnity arrangement in place, it is also a revalidation requirement. It is the professional responsibility Of all Healthcare Professionals, to ensure that you have cover,  which is appropriate to your role and scope of practice and its risks. We may undertake compliance checks, identification of failure to have the cover in place once you have signed a self-declaration will result in referral to the Professional Regulatory Body. |
| Occupational Health |
| Please be advised, that providing false information on the Medical Health Questionnaire, may result in breach of duty of mutual trust and confidence and misrepresentation. Subsequently, the employee's employment could be fairly and lawfully terminated, with possible civil court claim proceedings, as a result. |
| By signing this form, I declare that the information I have provided on this form is to the best of my knowledge, complete and accurate in respects. You understand that knowingly giving false information will disqualify me from registration with this agency, with a possible referral to the appropriate regulatory body. I also give consent that my file will be assessed for audit purposes by the relevant third party |

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| **Name:** |  | **Signature:** | **Date:** | **DD/MM/YY** |
| **Professional Registration Number:** |  |  |  |

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| **Referee’s Details** | | |  | | |
| Full Name: | | | Position: | | |
| Full Address including postcode: | | | Contact Number: | | |
| Email:  ***Please Note:*** *This reference may be disclosed to third party namely client organisations, for the purposes of audit, security verification.* | | | Please affix official stamp here or attach a complimentary slip | | |
| Applicant’s Details | | | Applicant’s Full Name: | | |
|  | Employed from / mm/ yyyy to / mm/ yyyy  How do you know this Applicant? | | | | Position Held:  Reason for leaving: |
| Please | Excellent | Good | | Very good | Average |
| Clinical Competency |  |  | |  |  |
| Attitude |  |  | |  |  |
| Punctuation |  |  | |  |  |
| Teamwork |  |  | |  |  |
| Flexibility |  |  | |  |  |
| Attendance /Sickness record |  |  | |  |  |
| Honesty |  |  | |  |  |

Would you re-employ the worker again? Yes / No If no please give reasons below

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| Additional Comments: |
| Declaration |

Print Name: -------------------------------------------------Signature: ---------------------------

Position: -----------------------------------------------------Date: ----------------------------------

**48 HOUR WAIVER**

The Working Time Regulations Act 1998 (the regulations) require 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 wishes to have an agreement with you. It proposes an agreement (which shall apply until terminated by notice) on basis that:

1. The 48-hour limit on average weekly working time will not apply to you.
2. You may terminate the agreement (so that the 48-hour time limit would not apply to you) by giving the managing director one-week written notice. For avoidance of doubt, any notice bringing this agreement to and shall not be construed as termination by the temporary worker of his/her employment with **ANK Solutions Ltd**
3. Under the regulations, the company must keep records relating to your working time. This is the case whether you reach an agreement with the company about waiving working time limits.

If you accept the company’s proposal, please sign and on the form provided. This document will not be a record of agreement between you and **ANK Solutions Ltd**

Print Name …………………………………………………………………………………………

Signed ……………………………………………. Date …………………………………….