



Mana Care

Mana Care Registration Form

Fill out the form carefully for registration

Position applied for:

Date of application:

How did you hear about the company?

Name*:

First Name

Last Name

Nationality:

Gender: M F

Birth Date*: Month Day Year

Address*:

Street Address

Street Address Line 2

City

State/Province

Postal/Zip Code

Country

Email*:

Mobile No:

Area Code

Phone No.

Phone No.*:

Area Code

Phone No.

National Insurance No.*

Are you a LTD Company?*

If Yes, Please provide LTD Company Details

NMC PIN NO: (If Applicable)

Which Language do you speak?

Have you ever been convicted of an offence?

Do you have permission to work in the UK?

Yes

No

Are you a car driver?

Yes

No

Next of Kin*:

Relationship*:

Contact Address*:

Contact Tel. No.*:

Bank Details:

Bank Name*:

Account Name*:

Account No*:

Sort Code*:

Qualifications and Education:

Employment History:

University/College (including dates attended)

Employment History: (including Dates Attended)*

DBS:

Are you willing to undergo a full enhanced DBS with this application for work?*

Yes No

Are you willing to pay the required fee of £49.60 for a DBS Disclosure check?*

Yes No

References:

Please give the names of two employers we can contact for an employment reference including the most recent employer

Name of Employer*:

Referee Name*:

First Name

Last Name

Address:

Street Address

Street Address Line 2

City

State/Province

Postal/Zip Code

Your Job title*:

Referee Phone No.

Area Code

Phone No.

Referee Email*:

Reference:

Reference No. 2:

Name of Employer*:

Referee Name*:

First Name

Last Name

Address:

Street Address

Street Address Line 2

City

State/Province

Postal/Zip Code

Your Job title*:

Referee Phone No.

Area Code

Phone No.

Referee Email*:

I agree for you to contact these references and only once references have been received will my application go any further. I certify that the information on this form to the best of my knowledge is correct. I understand that any engagement entered into will be subject to satisfactory references being received and a satisfactory DBS disclosure.

Signature*:

Date*: **Month** **Day** **Year**

Skills and Experience Checklist:

Please tick:

- Community Care**
- Hospital**
- Care Home**
- Nursing Homes**
- EM/Dementia Homes**
- Adults with Learning Disability**
- Adults with Mental Health Issues**
- Children with mental Health Issues**
- Physical Disability**
- Children's Homes**
- Supported Tenancy**
- Respite Centers**
- Day Care Centres**
- Prison Services**
- Hospices**
- Sheltered Accommodation**

- Autism/Asperger's Syndrome**
- Acquired Brain Injury**
- Palliative Care**
- Parkinson's disease**
- Diabetes**
- Epilepsy**
- Catheter Care**
- Stoma Care**
- Administration of Medicines**
- Challenging Behaviour**
- Person Centered Planning**
- Record Keeping**
- Bath/Shower/Strip wash**
- Mouth Care**
- Care of Feet**
- Dressing/Undressing**
- Bed Bath**
- Emptying Catheter Bag**
- Changing Colostomy Bag**
- Recording Fluid intake**
- Moving and Handling Service Users**
- Use of Waking Aids**
- Use of Hoists**
- Current Moving and Handling Course**

- Preparation of Meals
- Feeding Service Users
- Experience of caring for terminally ill
- Answering Telephone
- Talking Messages
- Bed making
- Changing a bed with a service user in it
- Light House work
- Experience of Dementia

Skills and Experience Checklist
Nurses Only

- Male Catheterization
- Female Catheterization
- IV Cannulation
- IV Medication
- IV Therapy
- Defibrillation
- Peg Feeds
- Tracheotomy Care
- Patient Controlled Analgesia
- Phlebotomy
- O₂ Therapy inc Nebulisers
- Wound Care
- Stoma Care

- Drains**
- Endoscopy**
- Use of Suction Equipments**
- Bladder washouts**
- B. M. Monitoring**
- Sub-cutaneous fluids**
- Naso-gastro tubes**
- Theatres / Recovery**
- Neurology**
- Intensive care units**
- Coronary care**
- Chest wards**
- A & E**
- Paediatrics**
- Orthopaedics**
- Haematology**
- Oncology**
- Cardiothoracic**

Individual Training Record:

**Please tick ALL training that you have completed:
(Please provide evidence of this)**

- Moving and handling practical**
- Health and safety**
- Infection control**

- First aid
- Deprivation of liberty safeguards
- Medication
- Epilepsy
- Mental capacity act
- Safeguarding of vulnerable adults
- Control and restraint

I can confirm that the information above is a true record of my training history*

Yes No

I am willing to attend mandatory training/specialist training as and when required*

Yes No

I can confirm I am happy to go through Mana Care trainings before I can start to work with them. The charge is £30.00*

Signature*:

Health Declaration*:

Do you have or have you had any of the following:

- Any serious infectious disease?
- Stomach, bowel problems, infections or food poisoning?
- Any allergy (including hay fever)?
- Fainting spells, blackouts or epilepsy?
- Any vision problems not corrected by glasses?
- Ear problems, infections or hearing defect?
- Dermatitis, eczema or any skin problem?
- Joint or back problems
- Any disability?
- Depression / mental illness / eating disorder?

- Diabetes?
- Are you taking any regular medication?
- Do you have any health problems that we should be aware of (including pregnancy)
- Chickenpox
- Hepatitis
- HIV/AIDS

I declare that all the above is true to the best of my knowledge. I am willing to provide details of my GP should the company require a medical report

Signature*:

EQUALITY AND DIVERSITY MONITOTRING FORM

Mana Care is committed to equal opportunities in employment and welcome applications from all sections of the community. In order to ensure the effectiveness of this policy and for no other purpose you are requested to place a tick in the appropriate boxes below and complete the details as required. The information is exclusively for monitoring purposes and will be kept strictly confidential.

Name*:

First Name

Last Name

Address:

Street Address

Street Address Line 2

City

State/Province

Postal/Zip Code

Job applied for*:

Sex: M F

Date of Birth*: **Month** **Day** **Year**

Status: Single Married Divorced Widowed

Please select the appropriate box that indicates your cultural background

- British**
- Irish**
- White**
- White & Black Caribbean**
- White & Black African**
- Indian**
- Pakistani**
- Bangladeshi**
- Caribbean**
- African**
- Chinese**

Any other background, please specify:

Please select the appropriate box that indicates your religious background:

- None**
- Buddhist**
- Muslim**
- Jewish**

Christian

Hindu

Sikh

Any other religion, please specify:

Sexual Orientation:

Heterosexual

Gay / Lesbian

Bisexual

Prefer not to say

The Disability Discrimination Act 1995 defines a disabled person as anyone who has a physical or mental impairment which has a substantial and long term effect on their ability to carry out normal day to day activities.

Taking this definition into consideration do you have a disability?

Yes No

If yes, then please give details:

Date*: Month Day Year

Signature*:

FAILURE TO COMPLETE THIS FORM WILL NOT AFFECT YOUR APPLICATION.
If you believe that there has been unfair discrimination in making the appointment, there is a process of investigation available, subject to reasonable grounds for suspicion being identified. If you wish to pursue an unfair discrimination complaint, please contact the Director of Mana Care.

WORKING TIME DIRECTIVES:

I understand that I am under no obligation to work more than an average of 48 hours in any week – these hours include any hours I work with other employers as well as Mana Care.

I further understand that I may work more than 48 hours per week if I wish

Under the terms of engagement, I realize that I may turn down any assignment at any time, for any reason without detriment.

By signing this declaration, I am signifying that any excess of an average of 48 per week are worked by my choice, but also mean that I will work more than an average of 48 hours in any week.

I undertake to inform if the total number of hours I work in a week from all forms of employment exceeds 48, in order that Mana Care may take this into consideration before offering work to me.

I understand that it is necessary to inform the agency of my availability for work each week and accept that there is no guaranteed hours of work.

Name*:

First Name

Last Name

Date*:

Month

Day

Year

Signature*:

IDENTIFICATION AUTHORITY:

In line with the requirements of current legislation I give Mana Care my permission to hold and transmit my photograph and date of birth, when necessary, to those clients who require identification cards when on assignment for them.

Name*:

First Name

Last Name

Date*: Month Day Year

Signature*:

CONFIDENTIALITY AGREEMENT

I confirm that during every assignment and afterwards:

- 1) *To hold information relating to the client in the strictest confidence, ensure it is kept safely and securely when not in use. I acknowledge that no information is to be removed from the clients premises without the permission of the client.*
- 2) *To use such information only for the purpose of the week for which it was given.*
- 3) *Not to disclose to any third party or copy the information except as it is required in the course of my duties.*
- 4) *Any breach, either by me or a third party, may result in legal proceedings being brought by the client against me to recover any losses that have occurred as a result of a breach.*

Name*:

First Name

Last Name

Date*: Month Day Year

Signature*:

Any conversations that compromise the patient relating to the above statement may jeopardise my position with Mana Care.

AUDIT:

I am aware that during the course of my time with Mana Care, my information may be required by an external party for auditing purpose. This includes my personal data and any other data relating to the work in question given to me by Mana Care to share my information and documents for the purposes of an audit for an auditor to check and review should the occasion arise. We would like to inform you that your details and information will be stored at our office for a period of six years. This is inline with GDPR policies.

Name*:

First Name

Last Name

Date*: **Month** **Day** **Year**

UNIFORM DEDUCTION FORM:

I accept that I must wear a uniform together with black trousers and black shoes (no high heels or trainers) on any care assignment with Mana Care. Jeans and non-closed shoes are not acceptable.

My Uniform Size is:

I am happy to pay a total fee of £20

I understand that I must not wear my uniform when working for anyone other than Mana Care.

I also give permission to Mana Care, to make deductions from my wages for the cost of my uniform.

I understand and agree to the above:

Name*:

First Name

Last Name

Date*: Month Day Year

Signature*:

WORKING WITH CHALLENGING BEHAVIOUR:

When working in this industry there are hazards associated with the industry. I appreciate and accept that one of these hazards is possible aggressive behaviour from challenging service users. Service users may present challenging and aggressive behaviour and this is out of the control of Mana Care.

I understand and accept that I am under no obligation as an agency worker to accept assignments. I accept that there is this risk and accept that this risk is as a result of the industry and not of Mana Care.

I understand that if I am unhappy with an assignment I can withdraw my submission at any time with reasonable notice dictated in my contract for service, and as a result will not hold Mana Care liable for any injury or loss of earnings as an agency worker.

I understand that as an agency worker I am not employed by Mana Care and therefore I am not guaranteed any assignments and have no claim against Mana Care at any time for any reason whatsoever for loss of any earnings as an agency worker.

I understand that if I am injured or affected in any other way whilst on an assignment that this is not the fault or liability of Mana Care.

I understand and agree to the above in its entirety

Name*:

First Name

Last Name

Date*: Month Day Year

Signature*:

CHARGES:

I also understand that I need to give at least 12 working hours' notice if cancelling a shift or I will be charged a fee of up to £50, we understand there are certain situations that cannot be helped and we will always take these into consideration. When cancelling a shift I understand that I should call the office phone numbers as well as texting.

I understand and agree to the above:

Name*:

First Name

Last Name

Date*: **Month** **Day** **Year**

Signature*:

SEVERABILITY:

If any of the provisions of these Terms shall be determined by any competent authority to be unenforceable to any extent, such provision shall, to that extent, be severed from the remaining Terms, which shall continue to be valid to the fullest extent permitted by applicable laws.

NOTICES:

All notices which are required to be given in accordance with these Terms shall be in writing and may be delivered personally or by first class prepaid post to the registered office of the party upon whom the notice is to be served or any other address that the party has notified the other party in writing, by email or facsimile transmission, when that email or facsimile is sent.

GOVERNING LAW AND JURISDICTION:

These Terms are governed by the law of England & Wales / Scotland and are subject to the exclusive jurisdiction of the Courts of England & Wales

Name*:

First Name

Last Name

Date*: **Month** **Day** **Year**

Signature*:

GDPR CONSENT:

In order to continue to keep you up to date with your payslips and future job opportunities, please respond below verifying you are happy to continue to receive this communication from us. As of the, 20....., we can no longer continue to communicate with you via Email, SMS or Post, unless we receive your permission to do so due to the new GDPR regulations.

Failure to respond will result in us being unable to send you your payslip via email on a weekly basis as well as any communication relating to Blissful Healthcare's activity.

I would like to receive communication via:

	Yes	No
Email	<input type="radio"/>	<input type="radio"/>
Post	<input type="radio"/>	<input type="radio"/>
Landline	<input type="radio"/>	<input type="radio"/>
Mobile	<input type="radio"/>	<input type="radio"/>

Name*:

First Name

Last Name

Date*: **Month** **Day** **Year**

Signature*:

Please select the branch you would like your application form submitted to:

- Reading Head Office**
- Bournemouth**
- Other**