Westcare Homecare Ltd

Carer Application Form

Personal Details	
Name:	
Date of Birth	
Address:	
Telephone No:	
Mobile No:	
Nationality:	
PPSN No:	
Email Address:	

In Case of Emergency (ICE) Contact Person:	
Name:	
Telephone No:	
Do you have a full drivers license?	Yes No
If 'Yes' give expiry date:	

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Do you have a car:	Yes No
When are you free to start work ?	

Education			
Secondary Level:			
Third Level:		State qualification	
Course	Yes/No	Expiry Date:	
Fetac level 5	Yes/No	Expiry Date:	
First Aid			
Manual Handling			
Food Hygiene			

Work Experience:		
	Present Employer:	Previous Employer:
Company Name:		
Address:		
Employment Period	To	To
Telephone no:		
Position Held		
Immediate Managers name:		
Telephone number:		
Reason for Leaving		

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Entitlement to work in Ireland		
Do you have European citizenship	Yes	No
Do you have a work visa?	Yes	No
If 'Yes' you will be required to show all work permit documentation		

Professional References	Please note we have the right to contact ALL previous employers		
Position:			
Company:			
Address:			
Telephone No:			
Fax No:			
Email:			

Availability:				
What hours/days/nights are you available to work as a carer				
Part-time Carer (please tick box you are available)				
Day:	**AM:**	**PM:**	**Evenings:**	**Overnight Stays:**
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				
Sitting services (supervisory only)		**Yes**	**No**	
Weekends only:		**Yes**	**No**	

Hours are not guaranteed and payment is made for contact time only. No payment will be made for induction or shadowin

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Carers Skills Checklist:	
Directions:	
Please carefully assess you strengths and select the appropriate level for each skill. This information will be utilized by our office when matching you with a client.	A. Proficient (expert) B. Experienced (perform independently) C. Familiar (may require assistance) D. No experience

	A	B	C	D	
Care of the older person					
Care of Alzheimer Client					
Care of client with stroke					
Care of client with head injuries					
Care of terminally ill					
Care of paraplegic or quadriplegic					
Care of client with respiratory difficulities					
Support/Care of clients with intellectual disabilities					
Care of the client with diabetics					
Care of the bed bound client					
Care of the amputee client					
Care and support of children					

Personal Care	A	B	C	D	Elimination	A	B	C	D	**Transfers**	A	B	C	D
Bed bath					Use of bedpan					Use of walker				
Sponge bath					Bowel program					Use of hoist				
Shower					Use of commode					Assist with ambulation				
Nail and skin care					Measure urine output					Transfer from bed to chair				
Hair care					Empty catheter bag					Use of wheelchair manual and electric				
Oral care					Change of catheter bags									
Brush														
Swab														

Westcare Homecare Ltd
Unit 10B Cleveragh Business Park, Cleveragh, Sligo
Tele No: 0719146768 Email info@westcarehomecare.ie, www.westcarehomecare.ie

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Denture					**Medication**					**Meal Preparation**				
Shave					Prompting with medication					Assist with feeding				
Assist with dressing					Assisting with medication					Follow feeding guidlines				
										Preparation of diabetic and low sodium diets				

Signature _____ Date _____

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Declaration of Health

Please answer yes or no and if yes, please give details in the space provided

	Yes	No	Details
Are you in good health at present			
Have you even been treated in hospital			
Have you ever suffered a work related illness or accident			
Or given up work because of ill health			
Do you smoke			
Do you drink alcohol			
Are you having treatment of any kind at this time			
Are you waiting for any treatment or investigation			
Have you been seen or examined by a GP in the last 6 months			
Do you have any problems with ears or hearing			
Do you have any problems with eyes or vision			
Do you have any physical limitation with may affect you ability to work			
Have you ever had any problems with your joint including pain, swelling or restricted movements			
Do you have any difficulty in standing, bending, lifting or other movements			
Have you ever had any kind of skin problem			
Have you ever had seizures, blackouts or epilepsy			
Have you ever had asthma, bronchitis or chest problems			
Have you or a member of you family ever had TB			
Have you had a cough for more than 3 weeks in the last 12 months			
Have you any heart or blood pressure			

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problems			
Have you unexplained weight loss or fever in the last 12 months			
Have you suffered from depression or emotional problems			
Have you a bladder or kidney disorder			

Are you on any medication at present			
Are you pregnant (please give due date)			
Do you have any allergies			
State vaccinations that you have received TB/BCG MMR Tetanus Hep B Influenza			

Westcare Homecare Ltd is an equal opportunities employer. All questions must be completed

I, _____of _____, _____

(Name) (address) (DOB)

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Hereby declare that

I have never been arrested for or convicted of any offences or crime (other than an offence under read 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 offences or crime (other than an offence under road traffic legislation for which a penalty of imprisonment if not enforceable)

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

I am not currently nor have I ever been to my knowledge under investigation by the Garda Siochana/Police force of any state in relation to the commission of a crime (other than an offence under the 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 nursing or medical professions.

I hereby authorize the Hospital and /or its relevant Health Service executive to make enquiries for the purpose of verifying and part of this declaration with An Garda Siochana and I or the regulatory body of 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. I confirm that I will inform Westcare Homecare of any convictions, pending or otherwise that occur after the date of signing this document and I accept that I am obliged to do so

Signed _____ Date _____

I give my permission to Westcare Homecare to give copies of relevant documents to the relevant appraisal bodies including HSE/or any other location for Auditing purposes or recruitment.

I give permission to Westcare Homecare to give my timesheets to Clients for auditing purposes and for the purpose of verification of signatures and to authorize payment

Are there any fitness to practice issues with you registration? No Yes

Signed _____ Date _____

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 4 months. Copy of working time Regulations Act is available to you upon request.

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