



CARE GIVER APPLICATION FORM

Comfort Keepers is an equal opportunities employer. All questions must be answered and application signed. Any application that does not provide requested information will be automatically rejected.

JOB DETAILS

Full Name: _____ Contact Numbers: _____
Current Address: _____

Email Address: _____

Date: _____

Where did you see the post advertised? _____

Do you drive? Yes No

Do you hold a full drivers license? Yes No

Do you own a vehicle? Yes No

Have you been employed by this company before? Yes No

When are you free to start? _____

Present / Previous Employer:

Contact Name: _____ Telephone Number: _____

Address: _____

Dates From: _____ To: _____ Position Held: _____

Main duties / responsibilities : _____

Immediate Managers Name: _____

Salary: _____ Benefits package: _____

Period of notice required: _____

If present employer – reason for this application: _____

Previous Employer:

Contact Name: _____ Telephone Number: _____

Address: _____

Dates From: _____ To: _____ Position Held: _____

Main duties / responsibilities : _____

Immediate Managers Name: _____

Reason for leaving: _____



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MEDICAL HISTORY

YOUR EMPLOYMENT WILL BE SUBJECT TO A SATISFACTORY COMPLETION OF A PRE-EMPLOYMENT MEDICAL QUESTIONNAIRE. THIS INFORMATION IS FOR THE HOME SUPPORT AGENCY AND DESIGNATED NURSING/MEDICAL OFFICER ONLY.

Section 1

Male Female

Family Doctor : _____.

Address : _____.

Section 2 Family History :

	State of Health (living)	Age at Death (If Not Living)	Cause of Death
Father			
Mother			
Number of Sisters			
Number of Brothers			
Spouse/Partner			

HAVE ANY MEMBERS OF YOUR FAMILY OR PARENT'S FAMILY DIED OF , OR AT ANY TIME BEEN AFFECTED WITH DIABETES, HEART DISEASE, MENTAL OR NERVOUS DISEASE OR TUBERCULOSIS.

If yes, please specify

Section 3 Previous Medical History

HAVE YOU EVER SUFFERED FROM : (Please tick the appropriate box)	No	Yes	IF ANSWER IS YES PLEASE GIVE FULL DETAILS
1. Heart or Circulation problems, rheumatic fever, blood pressure, breathlessness or chest pain on extraction.			
2. Hay fever, sinusitis, asthma, pleurisy, bronchitis, T.B or other disease of the lung.			
3. Do you have any of the following symptoms? persistent cough , sputum, coughing up blood , fever, tiredness, weight loss , breathlessness , night sweats. If yes, Please specify			
4. Are you aware of having been in contact with a person with Tuberculosis within the past two years ?			
5. Indigestion, stomach ulcer, colitis, jaundice or liver disorder or any other disease of the digestive system			
6. Blackouts, epilepsy, giddiness, fainting attacks , fits, convulsions.			
8. Diabetes, thyroid or other gland problems.			



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HAVE YOU EVER SUFFERED FROM:(Please tick the appropriate box)	NO	YES	IF ANSWER YES GIVE FULL DETAILS
9. Any disorder of the kidney or urinary tract.			
10. Dermatitis, eczema, or other skin trouble including allergies to latex / drugs / food ect.			
11. Back pain, slipped disc, whiplash or any muscle, bone or joint problem.			
12. Disease of the eyes, or ears, defective sight or hearing.			
13. Varicose veins, piles, rupture, hernia, anaemia, debility.			
14. Have you suffered from any other complaint not mentioned above?			
15. Have you ever had an accident or injury?			
16. Have you ever consulted a specialist, had an operation or been hospitalised.			
17. Have you been taking or are you currently taking any medication, tablets or pills.			
18. Have you ever had a chest X – ray , cardiograph or other special investigation carried out?			
19. What is your daily consumption of tobacco?			
20. How many units of alcohol do you consume weekly?			
21. Have you previously worked in industry where you were exposed to any hazards – dust, noise, chemicals?			

22. Please indicate which of the following vaccines you have received

Vaccinations

	Yes	No
B.C.G	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>
Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
M.M.R	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>



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TRAINING

Due to the portability of our company training, we require applicants to part fund their training to the value of €100. The training course is conducted by an external college and we cannot place any candidate without this training. This amount will be only deducted if you commence employment and will be deducted over a 12 month period. If you leave before 12 months any outstanding balance will be deducted from your final payroll.

ADDITIONAL INFORMATION

Please use this space to explain how you meet the specific requirements for a good care giver, including any personal / life experiences which you feel may be relevant to this position. Please continue on a separate sheet if necessary.

ENTITLEMENT TO WORK IN IRELAND

To comply with the employment legislation all prospective employees will be asked to supply evidence of eligibility to work in the Ireland. Please note that it is NOT company policy to sponsor candidates for work visas. We will need to see appropriate official document (for example, a document showing passport and student visa if applicable).

DO NOT SEND THESE NOW. Further information will be sent to you if you are short-listed.

What country is your passport issued? _____

Do you require any work permit / visa / Garda National Immigration Bureau card to work in Ireland?

YES NO

What is the expiry date of your Permit / Visa / Immigration/ Stamp 4 card? _____

Please note that you will be required to show your original work permit documentation.

PROFESSIONAL REFERENCES

These must be your manager, not colleagues (we reserve the right to contact all previous employers).

Name:	_____	Name:	_____
Company:	_____	Company:	_____
Position:	_____	Position:	_____
Address:	_____	Address:	_____
Telephone:	_____	Telephone:	_____
Fax:	_____	Fax:	_____
Email:	_____	Email:	_____

