PASSPOPRT SIZE
PHOTOGRAPH

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APPLICATION FOR EMPLOYMENT

PLEASE RETURN FORM TO **: ANYCLEAN PREMIUM LTD, PO BOX 790, DAGENHAM, ESSEX, RM9 9AD,**
TOGETHER WITH THE FOLLOWING DOCUMENTATION – A COPY OF YOUR PASSPORT (WITH VISA/WORK PERMIT IF REQUIRED), 2 PASSPORT SIZE PHOTOGRAPHS AND PROOF OF ADDRESS.

YOUR APPLICATION WILL NOT BE ACCEPTED WITHOUT THIS INFORMATION.

VACANCY APPLIED FOR:	

PERSONAL DETAILS

TITLE		**FIRST NAME(S)**		**SURNAME**	

ADDRESS		**DAYTIME TELEPHONE**	
		EVENING TELEPHONE	
		MOBILE	
	POSTCODE:	**E-MAIL**	

• **HOW LONG HAVE YOU LIVED AT THE ABOVE ADDRESS**: _____ YEARS _____ MONTHS

IF LESS THAN 3 YEARS PLEASE PROVIDE PREVIOUS ADDRESS: ____

____POSTCODE ____________________

DATE OF BIRTH		**NATIONAL INSURANCE NO:**	
NATIONALITY		**DO YOU NEED A WORK PERMIT**	**YES / NO**
IF YOU DO NEED A WORK PERMIT, PLEASE PROVIDE PROOF THAT YOU ARE ALLOWED TO WORK IN THE UK			
DO YOU HAVE ANY CLEANING EXPERIENCE?	**YES/NO**	**IF YES, GIVE DETAILS:**	
HAVE YOU USED CLEANING MACHINES BEFORE?	**YES/NO**	**IF YES, GIVE DETAILS OF CLEANING MACHINERY HANDLED:**	
DO YOU HOLD A FULL DRIVING LICENCE?	**YES/NO**	**IF YES, STATE LENGTH OF TIME LICENSE HELD**	
DO YOU HAVE ANY DRIVING CONVICTIONS?	**YES/NO**	**IF YES, GIVE DETAILS:**	

• DO YOU CONSIDER YOURSELF DISABLED UNDER THE DISABILITY DISCRIMINATION ACT? YES / NO

• DO YOU SUFFER, OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING - IF YES, PLEASE GIVE DETAILS; DATES AND TREATMENT. ARE THERE ONGOING SYMPTOMS AND IF SO WHETHER ANY WORK ACTIVITIES WILL BE AFFECTED? ALSO STATE IF YOU HAVE HAD ANY TIME OFF IN THE LAST 2 YEARS DUE TO THESE PROBLEMS.

	YES	NO	
HEART DISEASE, RHEUMATIC FEVER OR HIGH BLOOD PRESSURE			
DIABETES			
KIDNEY OR URINARY COMPLAINTS, OR BLOOD IN THE URINE			
RECURRENT STOMACH OR BOWEL COMPLAINTS, INCLUDING ULCERS OR HERNIAS			
ANY LUNG DISEASE, INCLUDING BRONCHITIS, TB, EMPHYSEMA OR ASTHMA			
ANY BACK OR NECK PAIN, ARTHRITIS OR ANY OTHER JOINT PAIN OR STIFFNESS			
RECURRING HEADACHES, FITS, FAINTS OR BLACKOUTS			
ANXIETY/DEPRESSION OR ANY OTHER NERVOUS DISORDER			
TREATMENT FOR DRUG OR DRINK DEPENDENCY			
HEARING DIFFICULTIES OR ANY OTHER EAR CONDITIONS			
DERMATITIS, ECZEMA OR ANY OTHER SKIN DISORDERS			
ANY SERIOUS ACCIDENT OR INJURY			
ANY HOSPITAL ADMISSION OR OPERATION			
ANY OTHER ILLNESSES OR DISEASE			
HAVE YOU CONSULTED A DOCTOR IN THE LAST TWO YEARS?			
ARE YOU ON ANY MEDICATION?			
HAVE YOU ANY MEDICAL COMPLAINTS AT THE MOMENT?			
PLEASE LIST ALL THE VACCINATIONS YOU HAVE HAD AND THEIR DATES.			

I CONFIRM THAT ALL THE ANSWERS GIVEN ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE. I HAVE NOT KNOWINGLY WITHHELD ANY INFORMATION AND RECOGNISE THAT DOING SO COULD BE SUFFICIENT GROUNDS FOR THE TERMINATION OF MY CONTRACT OF EMPLOYMENT. I GIVE PERMISSION FOR ANYCLEAN PREMIUM LTD TO CONTACT MY OWN DOCTOR.

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 SAFE TO WORK. THE CURRENT LIMIT IS 48 HOURS PER WEEK. BECAUSE YOU ARE UNDER NO OBLIGATION TO ACCEPT WORK OFFERED, YOU WILL NEVER BE COMPELLED TO WORK MORE THAT THE 48 HOURS PER WEEK BUT YOU MAY CHOOSE TO DO SO.

PLEASE SIGN BELOW TO CONFIRM THAT YOU HAVE READ AND UNDERSTOOD THIS IFORMATION, INDICATING YOUR PREFERENCE BY TICKING THE APPROPRIATE BOX.

I HAVE READ THIS IFORMATION REGARDING THE WORKING TIME REGULATIONS AND I UNDERSTAND THAT I DO NOT HAVE TO WORK FOR MORE THAN 48 HOURS PER WEEK.

☐ **I DO NOT WISH TO WORK MORE THAN 48 HOURS PER WEEK**

☐ **I DO WISH TO WORK MORE THAN 48 HOURS PER WEEK**

SIGNED: ____

DATE: ____

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WORK HISTORY

EMPLOYER	FROM	TO	POSITION HELD	DUTIES	REASON FOR LEAVING

EDUCATION AND TRAINING

SCHOOL/COLLEGE/UNIVERSITY ETC. ATTENDED	FROM	TO	QUALIFICATIONS GAINED OR COURSES STUDIED

ANY OTHER INFORMATION RELEVANT TO YOUR APPLICATION

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REFERENCES (NOT FAMILY MEMBERS AND ONE REFERREE MUST BE YOUR LAST EMPLOYER.)

NAME		NAME	
ADDRESS POSTCODE		ADDRESS POSTCODE	
TELEPHONE NO:		TELEPHONE NO:	
OCCUPATION		OCCUPATION	

NAME		NAME	
ADDRESS POSTCODE		ADDRESS POSTCODE	
TELEPHONE NO:		TELEPHONE NO:	
OCCUPATION		OCCUPATION	

NAME		NAME	
ADDRESS POSTCODE		ADDRESS POSTCODE	
TELEPHONE NO:		TELEPHONE NO:	
OCCUPATION		OCCUPATION	

NAME		NAME	
ADDRESS POSTCODE		ADDRESS POSTCODE	
TELEPHONE NO:		TELEPHONE NO:	
OCCUPATION		OCCUPATION	

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CONVICTIONS

REHABILITATION OF OFFENDERS ACT 1974

BY VIRTUE OF THE REHABILITATION OF OFFENDERS ACT **1974** (EXEMPTIONS) (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 NORMAL DUTIES. YOUR ANSWER TO THE FOLLOWING QUESTION SHOULD INCLUDE ANY "SPENT" CONVICTIONS.

HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENCE? YES/ NO

SIGNED: ____

DATE: ____

IF YOU HAVE ANSWERED "YES" PLEASE ATTACH DETAILS, INCLUDING DATES.

DATE	CONVICTION DETAILS

I DECLARE THAT I HAVE ANSWERED THE ABOVE QUESTION HONESTLY AND FULLY AND I AM NOT AWARE OF ANY PHYSICAL OR MENTAL DISABILITY WHICH WILL, OR MAY AFFECT MY WORKING CAPACITY. I REALISE THAT ANY FALSE OR INCOMPLETE STATEMENT ON MY PART WILL RENDER ME LIABLE TO DISCIPLINARY ACTION OR DISMISSAL. I ALSO UNDERSTAND THAT MY DETAILS MAY BE SUBMITTED FOR A POLICE CHECK IN RELATION TO THE CHILD PROTECTION LEGISLATION.

SIGNED: ____

DATE: ____

DECLARATION

I CONFIRM THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION GIVEN ON THIS ENTIRE FORM IS CORRECT.			
SIGNED		**DATE**	