

REGISTRATION FEE & PAYMENT TERMS

Registration Fee (Freshers Only): £150

This one-off fee applies to candidates new to UK healthcare. Candidates with six months or more verified UK healthcare experience are exempt, subject to valid employer references including your most recent employer.

DBS Certificate: £71

Mandatory Training: £100 (offline) or £90 (online)

These fees are waived if you hold a current DBS certificate registered with the update service and valid training certification. Verify eligibility with our office before payment.

Uniforms: £20 per tunic (minimum 2 required)

REGISTRATION FEE REFUND

The £150 registration fee is fully refundable after six months of continuous employment, subject to:

- Minimum 20 hours per week (part-time) or 33 hours per week (full-time)
- No unexplained gaps in service
- If minimum hours cannot be offered despite your availability (3.5 days part-time, 6 days full-time), refund eligibility continues with written confirmation from accounts@ecareuk.com

Training certificates are issued after six months upon written request to info@ecareuk.com.

PAYMENT INSTRUCTIONS

Account Name: Excellent Care Ltd

Account Number: 11096020

Sort Code: 60-04-35

Email payment receipt to hr@ecareuk.com. Application processing begins within three working days of receipt.

CANDIDATE DECLARATION

I acknowledge and agree to the fees and conditions stated above.

Name:

Signature:

Date:



Instructions for employers

This Starter Checklist can be used to gather information about your new employee. You can use this information to help fill in your first Full Payment Submission (FPS) for this employee. You need to keep the information recorded on the Starter Checklist record for the current and previous 3 tax years. Do not send this form to HM Revenue and Customs (HMRC).

Instructions for employees

As a new employee your employer needs the information on this form before your first payday to tell HMRC about you and help them use the correct tax code. Fill in this form then give it to your employer. Do not send this form to HMRC. It's important that you choose the correct statement. If you do not choose the correct statement you may pay too much or too little tax. For help filling in this form watch our short youtube video, go to www.youtube.com/hmrcgovuk

Employee's personal details

1 Last name

5 Home address

Postcode					
Country					

2 First names

Do not enter initials or shortened names such as Jim for James or Liz for Elizabeth

6 National Insurance number if known

--	--	--	--	--	--	--	--

7 Employment start date DD MM YYYY

--	--	--	--	--	--	--	--

3 Are you male or female?

Male Female

4 Date of birth DD MM YYYY

--	--	--	--	--	--	--

Employee statement

8 Choose the statement that applies to you, either A, B or C, and tick the appropriate box.

Statement A	Statement B	Statement C
<p>Do not choose this statement if you're in receipt of a State, Works or Private Pension.</p> <p>Choose this statement if the following applies.</p> <p>This is my first job since 6 April and since the 6 April I've not received payments from any of the following:</p> <ul style="list-style-type: none">• Jobseeker's Allowance• Employment and Support Allowance• Incapacity Benefit	<p>Do not choose this statement if you're in receipt of a State, Works or Private Pension.</p> <p>Choose this statement if the following applies.</p> <p>Since 6 April I have had another job but I do not have a P45. And/or since the 6 April I have received payments from any of the following:</p> <ul style="list-style-type: none">• Jobseeker's Allowance• Employment and Support Allowance• Incapacity Benefit	<p>Choose this statement if:</p> <ul style="list-style-type: none">• you have another job and/or• you're in receipt of a State, Works or Private Pension
Statement A applies to me <input type="checkbox"/>	Statement B applies to me <input type="checkbox"/>	Statement C applies to me <input type="checkbox"/>

Student Loan

For more guidance about repaying, go to
www.gov.uk/repaying-your-student-loan

9 Do you have one of the Student Loan Plans described below which is not fully repaid?

Yes If Yes, go to question 10

No If No, go to question 13

10 Did you complete or leave your studies before 6th April?

Yes If Yes, go to question 11

No If No, go to question 13

11 Are you repaying your Student Loan directly to the Student Loans Company by direct debit?

Yes If Yes, go to question 13

No If No, go to question 12

12 What type of Student Loan do you have?

Plan 1 Plan 2 Both

Student Loan Plans

You'll have a Plan 1 Student Loan if:

- you lived in Scotland or Northern Ireland when you started your course (undergraduate or postgraduate)
- you lived in England or Wales and started your undergraduate course before 1 September 2012

You'll have a Plan 2 Student Loan if:

- you lived in England or Wales and started your undergraduate course on or after 1 September 2012
- your loan is a Part Time Maintenance Loan
- your loan is an Advanced Learner Loan
- your loan is a Postgraduate Healthcare Loan

Postgraduate Loan

For more guidance about funding and repaying, go to
www.gov.uk/funding-for-postgraduate-study

For more guidance for employers, go to
www.gov.uk/guidance/special-rules-for-student-loans

13 Do you have a Postgraduate Loan which is not fully repaid?

Yes If Yes, go to question 14

No If No, go to the Declaration

You'll have a Postgraduate Loan if:

- you lived in England and started your Postgraduate Master's course on or after 1 August 2016
- you lived in Wales and started your Postgraduate Master's course on or after 1 August 2017
- you lived in England or Wales and started your Postgraduate Doctoral course on or after 1 August 2018

14 Did you complete or leave your Postgraduate studies before 6th April?

Yes If Yes, go to question 15

No If No, go to the Declaration

15 Are you repaying your Postgraduate Loan direct to the Student Loans Company by direct debit?

Yes

No

Fill in the declaration.

Declaration

I confirm that the information I've given on this form is correct.

Signature

Full name

Date DD MM YYYY



Excellent Care Ltd

The True Meaning for Care

HEALTH CHECK QUESTIONNAIRE

POSITION APPLIED

PERSONAL DETAILS:

Surname:

First Name:

Address:

Post Code:

Contact Tel:

Mobile:

GP Contact Details:

Please answer all the following questions by giving relevant details

1. Have you ever suffered from any of the following:

a) Depression, anxiety state, nervous illness or breakdown No if Yes,

b) Epilepsy or disease of the nervous system No if Yes,

c) Ailment of lungs or chest No if Yes,

d) Spinal problem (backache) No if Yes,

e) Arthritis, Rheumatism or Gout etc No if Yes,

f) Any heart or circulatory, including blood problems No if Yes,

g) Illness of the kidneys, bladder, liver or glands No if Yes,

h) Diabetes No if Yes,

i) Skin disorder No if Yes,

2) Are you presently taking medication or undergoing treatment. If so give details

3) What is your average daily consumption of:

Alcohol Tobacco

4) Are you a registered disabled person?

No Yes

5) Details of any industrial disablement benefit received:

6) How many working days have you been absent from during the last 12 months (apart from holidays)

7) Are you now pregnant?

No Yes N/A

8) Additional details: (If necessary)

DECLARATION

I confirm that the information given within this form is true and accurate. I hereby give consent for this information being used for personnel administration and business purposes.

Signature

Date

DD / MM / YYYY

Name

Once complete please send it to the respective branch



TYPE or PRINT in black ink

POSITION APPLIED

PERSONAL DETAILSTitle: Mr Miss Mrs Dr Other

Surname:

First Name:

D.O.B (optional): DD / MM / YYYY Marital Status: Nationality: NI Number: Address: Postcode: Contact Tel: Mobile: Email: **PASSPORT DETAILS**Passport No: Place of Issue: Issue Date: Expiry Date: DD / MM / YYYYVisa Status: Visa Expiry Date: DD / MM / YYYYIf student, please provide the course details: **NEXT OF KIN**Name: Relationship: Address: Tel: Mob: Email: **EDUCATIONAL QUALIFICATIONS**

Place of Study	Qualification	Date Qualified
<input type="text"/>	<input type="text"/>	<input type="text"/>

Use an additional sheet if necessary

TRAINING

Course Name	Date Attended	Expiry Date	Details(if necessary)

Use an additional sheet if necessary

WORK EXPERIENCE

From	To	Name of Employer	Type of Business	Job Title

Use an additional sheet if necessary

REFERENCE

Please give the names and contact details of two referees. One should be your previous Employer.

Name:	<input type="text"/>
Job Title:	<input type="text"/>
Relationship:	<input type="text"/>
Address:	<input type="text"/>
Company Name:	<input type="text"/>
Tel:	<input type="text"/>
Email:	<input type="text"/>

Name:	<input type="text"/>
Job Title:	<input type="text"/>
Relationship:	<input type="text"/>
Address:	<input type="text"/>
Company Name:	<input type="text"/>
Tel:	<input type="text"/>
Email:	<input type="text"/>

EQUAL OPPORTUNITY MONITORING FORM

The information on this form will be used in total confidence and accordance with current data protection legislation. It will help to ensure that the company property monitors and confirms with its policies relating to equality of opportunity. Information will be used for monitoring only. Our commitment aims to allow our staff to develop their skills and realize their maximum potential as individuals without any wish on the part of the company to limit their opportunity.

PLEASE TICK THE RELEVANT BOX

White

Mixed

Asian

Black

Chinese

Other PLEASE SPECIFY

Gender: Male Female

Please Indicate your age range by ticking one of the boxes below :

16-21

22-25

26-30

31-35

36-40

41-50

51-60

61-65

Do you consider yourself to have a disability of some kind ?

Yes

No

If Yes, give details

PROTECTION OF CHILDREN AND VULNERABLE ADULTS DECLARATION

Has any Social Service Department or Police Service ever conducted an enquiry or investigation into any allegations or that you may pose an actual or potential risk to children or vulnerable adults? Yes No

Have you ever been convicted of any offence relating to children or vulnerable adults? Yes No

Have you ever been the subject of any disciplinary procedure or been asked to leave employment or voluntary activity due to inappropriate behavior towards a child or vulnerable adult? Yes No

If no please sign the declaration below. If yes to any of these questions above, please give details.

REHABILITATION OF OFFENDERS

Because of the nature of the work for which you are applying, this post is exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974, by virtue of the Rehabilitation of Offenders Act 1974 (Exemptions) Order 1975. Applicants are therefore not entitled to withhold information about convictions, which for other purposes are spent under the provisions of the act and in the event of employment any failure to disclose such convictions could result in dismissal or disciplinary action by the employer. All Successful candidates will be required to obtain an enhanced disclosure report from the Disclosure and Barring Service. Have you ever been convicted of a criminal offence, or been subject to any confidential discharge, bind overs or caution.

Yes

No

If no please sign the declaration below, If yes please give details

I declare that I do not possess, nor have I ever possessed a criminal conviction, not have I been subject to any conditional discharges, bindovers or cautions.

Signature

Date

DD / MM / YYYY

Any information contained in this form will be treated in confidence. Failure to disclose any relevant information or providing false or inaccurate information may be regarded as a breach of any subsequent contract of employment, resulting in disciplinary action and/or dismissal.

PANEL AGENCY MEMBERSHIP

If you like to work through our panel agencies in various locations please sign the declaration below. This will help you to work with different clients in various locations through other agencies who are our partners. The related staff pay and other benefits are availed through the panel agency members directly. Please tick the box below if you are interested.

I have no objections in working with the panel agencies through E care solutions

Name:

Signature:

NOTES

DECLARATION

I confirm that the information given within this form is true and accurate. I hereby give consent for this information being used for personnel administration and business purposes.

Signature

Date

D D / M M / Y Y Y Y

Name

Once completed please send it to the respective branch.

FOR OFFICIAL USE ONLY (Application Check List)

Address with Postal Code:

Telephone & E-mail:

Qualification Certificates:

NI Number:

Emergency Number:

Passport Details:

Visa Details:

Next of Kin:

References:

Training:

DBS:

PVG:

If student, Course details:

NOTES:

Checked by:

Date

D D / M M / Y Y Y Y

CATERHAM

Excellent Care Ltd., 53 Westway, Caterham, Surrey, England - CR3 5TQ.
P: 01883338444 Email: info@ecareuk.com

Bank Account Details (Add / Change)

Title: Mr/Miss/Mrs/Ms/Dr/Other

Surname: _____ **Forename:** _____

Address: _____

Post code: _____

Tel no: _____ **Mobile No:** _____

Email: _____

Name of Bank: _____

Bank Address: _____

Sort Code No: _____ - _____ - _____

Account No: _____ (must be 8 digits long)

Name of Account Holder: _____

For office use only:

Employee payroll ID: _____

Employment Start Date: _____

