

INTER-COUNTY AMBULANCE SERVICE

Application Form



Please email completed form to:
info@intercountyambulance.com

APPLICANT INFORMATION										
Position Applied For						Date				
Last Name				First		DOB				
Address										
City				County		Post Code				
Phone				E-mail Address						
Date available to start work			National Insurance No.							
Nationality			Passport Number			Passport Current?		YES <input type="checkbox"/>		NO <input type="checkbox"/>
DRIVERS LICENSE										
Type of Driving Licence				No. of years held						
Type of Driving Experience										
Details of endorsements										
Number of penalty points			Number of accidents in last 5 years							
Details of Previous Convictions										
PROFESSIONAL DEVELOPMENT										
Date of Entering Profession				Date Qualified						
Highest Level of Qualification										
Certificate Number				Number of Years Accident and Emergency Experience						
Further Courses or Training										

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PRE-EMPLOYMENT HEALTH QUESTIONNAIRE

In order to comply with the Health and Social Care Act 2008 Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance, please complete this questionnaire as fully as possible.

Have you ever had or suffered from:

Epilepsy or Blackouts	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Nervous or Mental Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Migraine or Headaches	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Sensory Impairment	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Skin Allergies	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Back or Neck Pain or Previous Back or Neck Injury	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Heart Condition	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Asthmatic or respiratory ailments	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Recurring Incidents of Illness	YES <input type="checkbox"/>	NO <input type="checkbox"/>

If you wish to elaborate regarding answers to the above:

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Please list any vaccinations or immunizations currently in date:

Immunization	Date	Expiry
Immunization	Date	Expiry
Immunization	Date	Expiry
Immunization	Date	Expiry
Immunization	Date	Expiry
Immunization	Date	Expiry
Immunization	Date	Expiry

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PREVIOUS EMPLOYMENT		
Company		Phone
Address		Manager
Job Title		
Email Address		
Responsibilities		
From	To	Reason for Leaving
May we contact your previous manager for a reference? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Company		Phone
Address		Manager
Job Title		
Email Address		
Responsibilities		
From	To	Reason for Leaving
May we contact your previous manager for a reference? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Company		Phone
Address		Manager
Job Title		
Email Address		
Responsibilities		
From	To	Reason for Leaving
May we contact your previous Manager for a reference? YES <input type="checkbox"/> NO <input type="checkbox"/>		

DISCLAIMER AND SIGNATURE	
I certify that my answers are true and complete to the best of my knowledge.	
If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release from employment.	
Signature	Date

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DISCLOSURE AND BARRING

Due to the nature of the work involved, the post for which you are applying is exempt from section 4(2) of the Rehabilitation of Offenders Act 1974 by virtue of the Rehabilitation of Offenders Act (Exemption Order 1975). This means that you are not entitled to withhold information relating to any convictions that you may have had.

First Name	Last Name
Do you have a Criminal Record	
Have you ever been charged with any offence (other than speeding & parking) or is any prosecution pending	

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release from employment.

Signature

Date