

**PART A - APPLICATION FOR REGISTRATION AS AN INDIVIDUAL SOLE TRADER PROVIDING HOME CARE (i.e. *not operating an agency*)**

Application in accordance with Article 4 of the Regulation of Care (Jersey) Law 2014

Note that the receipt of incomplete information by the Care Commission may result in your application being refused.

*Please refer to guidance document while completing this form and use continuation sheets if necessary.*

**Section 1**
**1.1 Applicant Details**

<b>Full name</b>	
<b>Previous name (if applicable)</b>	
<b>Date of Birth (dd/mm/yyyy)</b>	
<b>Address line 1</b>	
<b>Address line 2</b>	
<b>Parish</b>	
<b>Post Code</b>	
<b>Telephone</b>	
<b>Email address</b>	

Please confirm if you are happy for your contact details to be included on our list of registered persons

 Yes 

 No 
**1.2 Previous history as a registered person**

With reference to care establishments, care agencies or care services regulated by any Law or Act in Jersey or elsewhere:

Do you currently provide or manage any care establishment, care agency or care service?

 Yes 

 No

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Have you provided or managed any care establishment, care agency or service in the past?

Yes

No

Have you ever been refused or had cancelled a registration of a care establishment, care agency or care service?

Yes

No

If you have answered Yes to any of the above questions please provide the following information

The name and address of the care establishment, care agency or care service

Details and dates of the registration

Contact details for the authority you were registered with

If you currently have, or ever had, a business or financial interest in any other registered care establishment, care agency or care service please provide details

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**1.3 Education and employment history**

Starting with your current employment please provide the employer's names and addresses, your dates of employment and reason for leaving for all positions held since compulsory education.

<b>Occupation/job title and Grade</b>	<b>From (mm/yyyy)</b>	<b>To (mm/yyyy)</b>	<b>Employers name and address</b>	<b>Reason for leaving</b>

Continue on separate sheets as necessary

Attached are [ ] extra sheets

Please provide full details explaining any gaps in your employment history

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**1.4 Professional Vocational and Technical Qualifications**

<b>Qualification</b>	<b>Awarding Body</b>	<b>Date of Award (dd/mm/yyyy)</b>

**1.5 Other relevant experience or training**

Please provide details of any other experience/skills or training which you believe are relevant to this application

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**1.6 Applicants who are health or social care professionals**

Name of Professional body	Registration reference number/PIN (where applicable)	Date of Expiry

Are you currently the subject of any investigation or proceedings being taken by any professional body with regulatory functions in relation to health or social care professionals in Jersey or elsewhere? Yes  No

If you have answered yes please provide details

Have you ever been disqualified from the practice of a profession or required to practice subject to specified limitations following a fitness to practice investigation by a regulatory body in Jersey or elsewhere? Yes  No

If you have answered Yes please provide details

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### 1.7 Medical fitness

Please either tick the box to declare that you are medically fit to manage a care establishment or service or provide a statement of medical fitness form signed by your doctor. There is no requirement to do both.

I confirm that, to the best of my knowledge, I am medically fit to manage a care establishment or service and that I will make the Care Commission aware if this changes

Alternatively, Please enclose with your application, the statement of medical fitness Form CCMR0 signed by your doctor, available from <https://carecommission.je/wp-content/uploads/2025/02/CCMR0-F-StatementOfMedicalFitness-Manager-20190102.pdf>

### 1.8 Criminal Record Disclosure

Have you ever been convicted of a criminal offence? Yes  No

Have you ever been sentenced to a term of imprisonment (whether immediate or suspended) without the option of a fine Yes  No

Are you aware of any prosecutions outstanding or pending court action against you? Yes  No

Are you currently subject to any criminal investigation Yes  No

If you have answered Yes to any of the above please provide details

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### 1.9 Business and Financial Standing

Have you ever been declared bankrupt? Yes  No

Have you ever been involved in an organisation that went bankrupt Yes  No

Have you ever been disqualified for holding office as a company director Yes  No

If you have answered yes to any of the above please provide details

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### 1.10 References

Please supply the names and addresses of two individuals from whom we may take up references. You must give the name of your current or most recent employer as the first reference. Neither of these referees may be a relative. Both of these referees must be able to provide comment on your skills and competence relevant to providing care and at least one must have employed you for at least three months in the last five years.

	Referee 1	Referee 2
<b>Title</b>		
<b>First name</b>		
<b>Surname</b>		
<b>Address Line 1</b>		
<b>Address Line 2</b>		
<b>Parish</b>		
<b>Postcode</b>		
<b>Telephone</b>		
<b>Email</b>		
<b>Occupation</b>		
<b>Capacity in which known</b>		

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If you are unable to provide details of one referee who has employed you for at least three months within the last five years, please explain why

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## Section 2

### 2.1 Details of Care Provided

I will be providing the following type of care

Type of Care	Please tick
Nursing care	
Personal care	
Personal support	

### 2.2 Number of care receivers

Please provide details of the number of people for whom you will be providing care

Number of People	
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### 2.3 Age Range of care receivers

Please provide details of the number of people for whom you will be providing care

What is the age range of the people you provide care to?	
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**2.4 Category of care**

Please indicate the category/categories relevant to the people for whom you will be providing care

<b>Category</b>	<b><i>Please tick</i></b>
<b>Adult 60+</b>	
<b>Dementia Care</b>	
<b>Physical Disability and/ or Sensory Impairment</b>	
<b>Learning Disability</b>	
<b>Autism</b>	
<b>Mental Health</b>	
<b>Substance Misuse</b>	
<b>Other (<i>please specify</i>)</b>	

**2.5 Details of people for whom you will be providing care**

<b>Full name</b>	
<b>Address line 1</b>	
<b>Address line 2</b>	
<b>Parish</b>	
<b>Post Code</b>	
<b>Telephone number</b>	
<b>Number of hours per week employed</b>	
<b>Details of the person who has arranged the care package</b>	

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<b>Full name</b>	
<b>Address line 1</b>	
<b>Address line 2</b>	
<b>Parish</b>	
<b>Post Code</b>	
<b>Telephone number</b>	
<b>Number of hours per week employed</b>	
<b>Details of the person who has arranged the care package</b>	

<b>Full name</b>	
<b>Address line 1</b>	
<b>Address line 2</b>	
<b>Parish</b>	
<b>Post Code</b>	
<b>Telephone number</b>	
<b>Number of hours per week employed</b>	
<b>Details of the person who has arranged the care package</b>	

If you are providing care for more than three people please use continuation sheet

### 2.5. Charges

Please provide details of the hourly rate you charge and any additional charges for items or services not covered by the hourly rate.

<b>Hourly rate</b>	
<b>Charges for items or services not covered by the hourly rate</b>	

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### Section 3

#### 3.1 Documents to be supplied with the application

	Tick
• Application form signed and completed in full	
• Valid photo identification	
• Originals of any professional or technical qualifications	
• Enhanced DBS Certificate	
• Training Certificates	
• Statement of Purpose	
• Current public liability insurance certificate	
• Statement of medical fitness signed by your doctor (Form CCMR0) or complete the self-declaration in section 1.7	
• Fee payment - we will invoice you for all the requisite fees.	

*Please refer to the fee schedule provided within the guidance document for details on the registration fee applicable to your service type*

### Section 4

#### 4.1 Application Declaration

*This declaration must be signed by the applicant*

I certify that the information detailed this application is, and the documents accompanying the application are to the best of my knowledge and belief true and complete. I understand that under Article 45 of the Law, that to knowingly make false or misleading statements is an offence that may result in prosecution and the registration being refused.

I confirm that I am a sole trader, directly employed by an individual care receiver (or his or her representative) to provide care/support and I do not employ or otherwise pay any other person to assist in the delivery of care/support to the care receiver.

I understand that it is a requirement under Regulation 20 of the Regulation of Care (Standards and Requirements) (Regulations) 2018 to notify the Care Commission of any information that is relevant to my application/registration and to update this information accordingly.

I have knowledge and understanding of my legal responsibilities in relation to the provision of home care and intend to do so in accordance with legislative requirements, the Care Commissions Standards and other relevant standards set by professional bodies and standard setting organisations. I understand that failing to meet the relevant legislation will lead to the refusal of this application and after registration is granted may result in the cancellation of registration.

I understand that the Care Commission will use information provided in this application (including personal data and other relevant information the Care Commission obtains and receives) for the purposes of performing its regulatory function. In particular this information will be used to make regulatory judgements in relation to the registration of individuals and providers and in relation to monitoring compliance with regulations. Information (including personal data) may also be shared

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with other regulators and public bodies where necessary to assist in the exercise of public functions and/or for the protection and welfare of any individual. (Please refer to [www.carecommission.je](http://www.carecommission.je) for more information about how data is handled).

By submitting this application I agree that the information contained in this form may be used to form conditions of registration.

Applicant Name ( <i>please print</i> )	Signature	Date ( <i>dd/mm/yyyy</i> )

Please return the completed application and all required documentation marked **Confidential** to:

Applications Processing  
Jersey Care Commission  
1<sup>st</sup> Floor, Capital House  
8 Church Street  
St Helier  
Jersey JE2 3NN  
Email: [notifications@carecommission.je](mailto:notifications@carecommission.je)

Appendix 1 Continuation sheet

**Continuation Sheet** *(please identify the section within the application to which this sheet refers)*

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**Appendix 2 Continuation sheet section 1.3 Employment History**

<b>Occupation/job title and Grade</b>	<b>From (mm/yyyy)</b>	<b>To (mm/yyyy)</b>	<b>Employers name and address</b>	<b>Reason for leaving</b>

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**Appendix 3 Continuation sheet section 1.4 Professional Vocational and Technical Qualifications**

Qualification	Awarding Body	Date of Award (dd/mm/yyyy)