

# FORM A

**FORMS A & B MUST BE RETURNED BY EMAIL TO [ADMIN@MANE.CO.UK](mailto:ADMIN@MANE.CO.UK) OR FAX TO 0845 833 1614. NON RETURN OF FORM A & B WILL DELAY PAYMENT.**

Of:

Mobile:

It is a requirement of the Working Time Directive that all workers require a health assessment before they start. Please complete the questions below and return them to us with a signed declaration for our records.

Date of any previous health assessments:

Do you currently suffer from Diabetes?	Yes	No
If yes do you require insulin injections?	Yes	No
Do you suffer from heart or circulatory disorders?	Yes	No
If yes does this affect your physical stamina?	Yes	No
Do you suffer from stomach/digestive disorders e.g., Ulcers?	Yes	No
Do you suffer from a medical complaint which means the Regular timing of meals is important?	Yes	No
Have you ever had a medical condition which affects sleep?	Yes	No
Do you suffer from a chronic chest disorder which needs medication to be taken according to a strict timetable	Yes	No
Do you suffer from epilepsy?	Yes	No
Are you aware of any medical condition from which you suffer, which you feel could detrimentally affect your ability to carry out an assignment for us?	Yes	No

If yes please give details:

I declare that I have completed this form accurately and to the best of my knowledge and belief. If deemed appropriate as a result of the information I have given here, I give my consent to be referred to a health professional for a more thorough assessment. **\*Medical information is held in the strictest of confidence and will not be made available to any other organisations\*** I understand that according to the European Working Time Directive there exists a clause that states I do not have to work over 48 hours per week unless I agree to do so. The Directive states that there are safeguards to protect workers from suffering detriment by not agreeing to not apply the Directive and this will be enforced on the agreement.

I am prepared to work over 48 hours per week and agree to NOT APPLY The Working Time Directive until such time as I notify you in writing of my desire for the provisions of the Working Time Directive to apply

I wish to APPLY the Working Time Directive and do not wish to work over 48 hours per week

**PLEASE COMPLETE THE BOX BELOW BEFORE RETURNING YOUR FORMS:**

Next of Kin:

Contact Number:

Relationship:

## FORM B

Of:

Mobile:

We understand that you have appointed the company listed below to administer your tax affairs and liability. You confirm that you understand the tax implications and liabilities of using your chosen limited company and that it has not been recommended by Mane Contract Services. The chosen Limited Company is independent from Mane Contract Services and as such any tax liability will be settled by you or your Limited Company.

We will need the following information in order to pay your Limited Company:

- Limited Company Certificate of Incorporation
- Proof of Limited Company's bank details (paying in slip, blanked out statement, voided cheque)
- Limited Company's UTR number for CIS purposes.
- VAT certificate (if the Limited Company is VAT registered)

If you are part of an umbrella company we may already have the necessary information to process payment.

Please check with our Administration Department on 01923 470530 to establish this.

For invoice purposes your Limited Company will need to sign a Self-Billing agreement. We have attached this so please forward it to your Limited Company administrator to sign and return to us.

If your Limited Company does not opt in to the Self-Billing agreement then accompanying your timesheet we will require an invoice before payment can be made to your Limited Company.

Ltd Company name

**I CONFIRM THE DETAILS ABOVE ARE WHERE I WISH ALL PAYMENTS TO BE DEPOSITED AND THAT THEY WILL APPLY TO THIS ASSIGNMENT AND FUTURE ASSIGNMENTS. IT IS UNDERSTOOD ANY CHANGES TO THE ABOVE HAVE TO BE IN WRITING WITH FIVE WORKING DAYS NOTICE.**

**YOU DO NOT NEED TO RETURN THIS FORM IF YOU HAVE PREVIOUSLY WORKED FOR MANE AND COMPLETED THIS FORM USING THIS LTD COMPANY.**

**Please insert your name and date here to confirm the above information is true and accurate:**

X

X

Name:

Date: