Nurses Application form

Perfect Quality Care Ltd

Excellent Tailored Care

PERFECT QUALITY CARE
First Floor,
Email:info@perfectqualitycare.com
Tel: 0208 Fax: 0208

NURSES APPLICATION FORM

Personal Details

Title: Surname:

Forename: Maiden Name:

Middle Maiden: Marital Status:

Date Of Birth Male: Female:

Age: National Insurance:

Address:

City / Town: Country:

Postcode: Home Telephone;

Mobile Phone: Work Phone:

Pager No: Email Address:

Preferred Contact Method :

Are You Willing To Expect Morning Calls?: Yes: No:

Are You Willing To Expect Late Night Calls?: Yes: No:

Various Information

Work Status: Passport Number: Exp Date: /

Nationality: Birth Certificate No:

Home Office Letter Ref: Have Work Permit? Yes: No:

Work Permit Type: Expiration Date:

Name Of College/University (If Student):

Studying Nursing?: Yes No If Yes, When Do You Graduate?:

Are You Undergoing Adaptation?: Yes: No: If Yes, Give Your Completion Date:

Have Your Own Transport?: Type Of Transport:?

Have You A Driving License?: Yes / No If Yes Any Endorsement?

Religion: Ethnic Origin:

Children Under 18 Years? : Yes / No Ages:

Do You Smoke?: Yes / No Registered Disabled? Yes No

Registration No:

Give Details Of Hobbies / Leisure Activities:

Professional Education & Training

Please List Any Training / Course / Nursing Qualification You Have And When You Gained Them

Qualification: School / College /University: Dates Gained

NMC Pin No:

Where obtained:

Registration date: Expiration Date:

Please Tick The Nursing Specialities of Which You Have Significant, Post Training Experience. Please Remember You Will Be Held Accountable For Any Missing Information.

SPCIALISM (Nursing)	LESS THAN 6 MONTHS	MORE THAN 6 MONTHS	1- 2 YEARS	2 YEARS +
Medical				
Learning Disability				
ITU Psychiatric				
Intensive Care Unit				
In charge Duties				
Hospitals				
Hospices				
Home Care				
High dependency				

Unit				
Health Visitors				
Haematology				
Gynaecology				
GU Med				
Dental				
District Nursing				
Family planning				
Urology				
Mental Health				
Stoma Care				
Theatre				
Renal				
Residential Homes				
Paediatric				
Oncology				
Midwifery				
Nursing Homes				
Out patients				
CSSD				
Neonatal				
Care of the elderly				
Practice Nurse				
GU Med				
Recovery				
Prisons				
Surgical				
Occupational Health				
Mental health				
Orthopaedics				
PICU				
SCBU				
A & E				
Cardiac				
ODP /ODA				
Neurology				
Radiology				
Scrub				
Theatre				
Day Surgery				
Intensive Care Unit				
Day Care Centre				
School Nurse				
Ante Natal				
Cardiothoracic				
Chemotherapy				
Anaesthetic				

Trained				
Medical Assess unit				

MID WIVES ONLY

Midwives Please Circle The Appropriate Box

Are You Practising?: Yes: No:

Intention To Practice Completed?: Yes: No:

Expiration Date: / /

Employment History

Please Give Details Of Your Past 5 years Of Continuous Work History Giving Reasons For Any Breaks In Employment.

From: / / To: / / Employer:

Address:

Telephone: Main Contact:

Post Title; Grade:

Full-time or Part-time: Salary:

Main Responsibilities:

Department / Ward:

Reason for Leaving:

From: / / To: / / Employer:

Address:

Telephone: Main Contact:

Post Title; Grade:

Fulltime or Part-time: Salary:

Main Responsibilities:

Department / Ward:

Reason for Leaving:

From: / / To: / / Employer:

Address:

Telephone: Main Contact:

Post Title; Grade:

Fulltime or Part-time: Salary:

Main Responsibilities:

Department / Ward:

Reason for Leaving:

From: / / To: / / Employer:

Address:

Telephone: Main Contact:

Post Title; Grade:

Fulltime or Part-time: Salary:

Main Responsibilities:

Department / Ward:

Reason for Leaving:

Health Education

Have You Been Vaccinated Or Tested Against The Following:?	YES	NO	DETAILS (Plus dates if YES)
Hepatitis B			
Hiv			
Tetanus			
Poliomyelitis			
Typhoid			
Rubella (German Measles)			
Tuberculosis And BCG			
Hepatitis B Antibodies			
Mantoux, Tine Or Heaf			
Varicella			
Last X-Ray			
Others (Specify)			
Do You Or Have You At Anytime Suffered From Any Of The Following?	**YES**	**NO**	**Details. (Required If YES)**
Skin Complaints- Dermatitis, Psoriasis, Eczema			
Diabetes Or Glandular Complaints			
Headaches Or Migraine			
Hypertension/ Heart Problems/ Similar Illness			
Back Pains / Back Injury Or Problems			
Jaundice / Hepatitis			

Epilepsy Or Fainting Attacks			
Pleurisy /Bronchitis / Pneumonia			
Asthma			
Infections - Ear / Sore Throat			
Psychiatric/ Mental Disorder/ Depression Etc			
At Present Are You Having Any Injections/Medications	YES	NO	Details (if YES)
Are You Under Any Treatment Of Any Kind Of Condition?			
Have You Had Any Major Operations?			
Physical Disabilities?			
How Much Time Have You Taken Off Work In The Last 5 Years Due To Illness?.			
Please State Any Other Information About Your Health Which May Affect Your Work			

If you do not have vaccination information , please provide details of where we can request them below.

I Certify The Above Information Is Correct And Hereby Give Permission To General Response Health and Social Care To Request A Further Report From My GP/ Occupational Health/ Hospital For Clarification If Required And For My Health Report

GP / Occupational Health / Hospital: .....

Address: .....

.....

Tel: ..... Mobile: .....

Email address: .....

Signed (Applicant: .....

Work Preferences

What Kind Of Nursing Work Are You Interested In? (Tick All That Apply)

NHS: Private Hospital: Nursing Home:

Residential Home: Others :

(Please Specify) Short Term: Long Term

Please Indicate When You Would Like To Work. Please Tick All Relevant Boxes.

Daily.

Part-Time: Full-Time: Bank Holidays:

Evenings (M-F): Days (M-F): Nights (M-F):

Evenings (Sat-Sun): Days (Sat-Sun): Nights (Sat-Sun):

Availability:

From When Are You Available To Work?:

Come For An Interview?:

Do You Have Any Holiday Booked? If yes, When?:

Rehabilitation Of Offenders Act 1974.

Because of the nature of the work for which you are applying, this post is exempt from the provisions of section 4.2 Rehabilitation of Offenders Act 1974 (Exemption Order 1975). Applicants are therefore, not entitled to withhold information about convictions, which for other

purposes are 'spent' under the provision of the Act in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action. Information provided will be kept confidential and use in relationship to the post applied for.

Have You Ever Been Convicted Of A Criminal Offence? YES:
No:

If yes, please specify

Do You Have Any Spent Or Unspent Convictions? Yes: No:

If yes, please specify

Have You Instigated An Enhanced Disclosure Within The Last Six Years?

Yes: No:

I Consent To General Response Health and Social Care Ltd Checking The Details I Have Provided Against The Various Data Sources In Order To Verify My Identity And Process This Application.. This Details Maybe Use To Assist Other Organisation Such As DBS CHECKS, NMC In Identity Purposes.

Signature: **Date:**

References.

Please Give The Names And Addresses Of Two Of Your Most Recent Employers With Work Addresses Who Is Able To Comment On Your Work Ability And Experience. Starting With Your Present To Most Recent Employer If Possible.

(A)

Name of Reference:

Company's Name:

Address:

Postcode: City / Town: Country

Telephone No: Fax:

Email Address: Mobile No:

Start Date: / / End date: / / To date:

(B)

Name of Reference:

Company's Name

Address:

Postcode: City / Town: Country

Telephone No: Fax:

Email Address: Mobile No:

Start Date: / / End date; / / To date:

Building Society /Bank Details

Bank Name:

Bank Address:

Building Society Bank Roll:

Account Holder's Name;

Sort-Code: Account No:

I authorise General Response Health and Social care Ltd to pay my weekly wages into the above Bank Account and I will notify General Response Health and Social care Ltd if changes occur to my details.

Signed: **Date:**

Next Of Kin

Name of Emergency Contact: Relationship to you:

Address:

Post Code: Home Telephone;

Work No; Email Address:

Mobile No: Pager No:

Working Time Regulations

According To The Working Time Regulations,

1) You are not required to work more than 48 hours per week except agreed in writing.
2) An Agency staff is entitled to 11 hours rest from work in each 24 hours and 12 hours if under 18 years.

3) A minimum of 20 minutes break when the working day is longer than 6 hours.
4) Staff should not work 8 hours in every 24 hours if it is night work.
5) Staff is entitled to a minimum of 1 day rest from work each week or 2 days every 2 weeks.
6) Staff is entitled to 4 weeks paid annual leave once they have worked through a particular agency for a continuous 13 weeks period.

I have read and understood the Working Time Regulations and I hereby consent that the working time limit shall not apply to my assignments.

Print Name .....

Signed ..... **Date** .....

Final Statement

I Declare That The Information Provided On This Application Is True To The Best Of My Knowledge. I Have Read The Terms And Condition Of Engagement And Agree To Comply With The Current Health And Safety At Work Act. I Understand That My Appointment Is Subject To The Receipt Of Two Satisfactory References And It Subject To Enhanced DBS Disclosure. **General Response Health and Social care i**s Free To Make Any Other Enquiries They May Find Necessary Relating To My Application. I Agree To Respect The Confidentiality Of Patients And Clients And Any Other Information I May Have Access To.

Signed ..... **Date** .....

Agency Information / Office Use

CHECKLIST		**NOTES**
Application		
Proof of Address	Utility bills, bank statements, others.	
Proof of identity	Passport, driving license others	
Eligibility to work	Visa, Work Permit,, passport, birth cert	

NMC Pin No		
DBS / CRB Application		
48 hours apt out		
PAYE Form		
2 passport photographs		
Immunisation		
Signed contract		

Agency Sign Off

I Certify that I interviewed the above applicant in accordance with the **General Response Health and Social care** requirements and I am satisfied that this applicant is cleared for work.

Name Of Consultant: .....

Signature of Consultant: .....

.....

Date: .....