**APPLICATION FORM**

Please ensure you:

* Complete all the sections of this form
* Send us all the required documents promptly
* Complete this form in CAPS letters

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| **SECTION A – PERSONAL DETAILS** |
|  |
| Title (MR, MRS, MISS or Other) |  |
| Surname (Family Name) |  |
| First Name(s) |  |
| Other Names(s) |  |
| Maiden Name (if any) |  |
| Drivers Licence? Yes No | Male | Female  | Prefer not to say |
| Address |  |
|  |  |
| Post Code |  | Country |  |
| Home Tel No. |  | Mobile Tel No. |  |
| Email Address |  |
|  |  |
| Next of Kin Details: |
| Full Name |  | Relationship |  |
| Tel. Home No. |  | Tel Mobile No. |  |

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| --- | --- |
| Languages spoken |  |

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| Professional Indemnity Insurance: |
| Do you have your own Professional Indemnity Insurance? Yes No  |

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| **SECTION B – PASSPORT DETAILS**Please note, all passports and visas will be checked and verified as part of the recruitment procedure |

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| National Insurance No. |  | Date of Birth | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |
| Your Nationality |  |
| Passport No. |  | Expiry Date | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |
| Do you hold a British or EU Passport? Yes No  |
| If you do not hold a British / EU Passport, do you hold any of the following? |
| Indefinite Leave to remain in the UK | Ancestry Visa |
| Spousal / Partnership Visa | Biometirc Residence Permit |
| Work Permit / Sponsorship (Tier 2)  | Student Visa (Tier 4)  |
| Working Holiday Visa / Youth Mobility Visa (Tier 5)  | Other? (Please Specify)  |
| Visa Expiry Date | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |

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| **SECTION C – PROFESSIONAL DETAILS** |
| Membership of Professional Body (give details) |  |
| NMC Pin Number |  |
| NMC Expiry Date | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |

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| **SECTION D – WORK REQUIREMENTS**  |
| Position Applying For |  |
| Ideal Work Settings? Hospital, etc |  |
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| Flexible Agency Work | Full Time Hours |
| Part Time Hours | Ad hoc shifts 1-2 per week |
| Short Term Contract | Long Term Contract |

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| Preferred hours |
|  |
| Please tick the days you prefer to work |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Mon | Tue | Wed | Thurs | Fri | Sat | Sun |
| Days |  |  |  |  |  |  |  |
| Nights |  |  |  |  |  |  |  |

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| **SECTION D – WORK REQUIREMENTS** *(Continued)* |
| What area do you prefer to work? City |  |
| Clinical Areas of Expertise (Please select up to six areas of speciality) |

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| A&E |  | Cardiac |  | Clinic |  |
| Community |  | Diagnostic Imaging X-Ray |  | Elderly Care |  |
| Endoscopy |  | General Wards |  | Gynaecology |  |
| HDU |  | Health Visitor |  | Homecare |  |
| ITU |  | Learning Disabilities |  | Medical |  |
| Mental Health |  | Midwifery |  | Neonatal |  |
| NICU |  | Nurse Practitioner |  | Nursing Home |  |
| Occupational Health |  | ODP |  | Oncology |  |
| Chemotherapy |  | Orthopaedics |  | Paediatric A&E |  |
| Paediatrics |  | Palliative Care |  | PICU |  |
| Practice Nurse |  | Prison |  | Radiology |  |
| Recovery |  | Renal |  | Dialysis |  |
| SCBU |  | Surgical |  | Theatre |  |
| Triage |  | Urology |  | Walk in Centre |  |
| Dietician |  | Psychologist |  | Radiographer |  |
| Occupational Therapists |  | Speech and Language Therapist |  | Podiatrist |  |
| Orthoptist |  | Cytologist |  | Pathologist |  |
| Biomedical Scientist |  | Health Scientist |  | Dental Care |  |
| Genetic Counsellor |  | Pharmacy Staff |  | Medical Technologist |  |
| Optometrist |  | Physiotherapist |  | School |  |

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| Have there been any conduct proceedings of medical or professional negligence or misconduct against you and have you ever been suspended or dismissed from any roles? Yes No  |
| If you answered yes to the above please supply details  |  |
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| **SECTION E – EDUCATION & TRAINING** |

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| --- | --- | --- | --- |
| Name and Address of School/College/University | Course or Subjects taken and qualifications gained | FromM / Yr | ToM / Yr |
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| **TRAINING AND DEVELOPMENT** |
| Please use the space below to give details of any training or non-qualification based development which is relevant to the post and supports you application. |
| Training Body and Course details | Date | Qualification achieved |
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| **SECTION F – EMPLOYMENT HISTORY***Please list most recent employer first and provide us with 10 years history, accounting for any gaps in employment if over one month. Please state month and year for each period of employment.* |

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| Previous Employer(s) and address(es) Please include any voluntary work | Position(s) held | FromM / Yr | ToM / Yr |
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(continue on separate sheet if necessary)

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| **SECTION G – REHABILITATION OF OFFENDERS ACT 1974** |
| Due to the nature of work for which you are applying, this post is exempt from the provisions of Section 4 (2) of the rehabilitation of Offenders Act. 1974 (Exception Order 1975). Applicants are therefore not entitled to withhold information about convictions which for the 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. Any information given will be completely confidential, and will be considered only in relation to an application for positions in which the order applies and should be entered at the end of any particulars you give in support of your application. A written policy is available upon request. A criminal record will not necessarily be a bar to obtaining a position.  |
| Your Answer to the following question should include any ‘spent’ convictions. |
| Have you ever been convicted of a criminal offence? Yes No  |
| If yes please supply the details:  |  |
|  |
| You may be offered an opportunity to work within an Environment or establishment where you come into contact with children or other vulnerable groups, or your professional occupation may fall within certain expected categories where this is likely to apply, the Rehabilitation of offenders Act 1974 (exceptions) Order 1975 required us to ask you for additional information. A DBS disclosure (Disclosure Baring Service) may be required when this type of work is sought.  |
| Do you have any previous convictions within the Act, including any cautions, reprimands, final warnings or convictions from overseas? Yes No  |
| If yes, please supply the details:  |  |
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| **SECTION H – REFERENCE DETAILS** |
| Please supply details of 2 professional clinical referees. Business addresses only, no home address.Please supply one from your present employer and must be your direct line manager, a senior grade to yourself.Please advise your referees that we will be in contact with them as soon as we receive your application.  |
| Referee Details 1 |
| Full Name |  | Position |  |
| Daytime Tel No. |  | Tel Mobile No. |  |
| Email Address |  |
| Work Address  |  | What Capacity was the referee known to you? |
|  |  |
| Postcode |  | How long has this person known you? |  |
|  |
| Referee Details 2 |
| Full Name |  | Position |  |
| Daytime Tel No. |  | Tel Mobile No. |  |
| Email Address |  |
| Work Address  |  | What Capacity was the referee known to you? |
|  |  |
| Postcode |  | How long has this person known you? |  |
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| **SECTION I – PAYROLL DETAILS** |
| Your Details: |
| First Name (s) |  | Surname(s) |  |
| Tel/Mobile No. |  | Date of Birth |  |
| How are you currently paid? |
| Limited Company | PAYE |
| Umbrella Company | Self Employed |
| Your Bank Account Details: |
| Name of Bank |  | Bank Account Name |  |
| Sort Code |  | Bank Account Number |  |
| Bank City / Town |  | Bank Postcode |  |

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| **SECTION J - DECLERATIONS** |
| Working Time Directive:The Working Time Regulations 1998 require Vital 24 Healthcare Ltd to limit your average weekly working time to 48 hours unless you agree with Vital 24 Healthcare Ltd that the limit shall not apply to you: |
| **I agree to limit my working week to no more than 48 hours** |
| **I disagree to limit my working week to no more than 48 hours** |
| * I understand that if I provided Vital 24 Healthcare Ltd with incorrect bank details, this would delay payment
* I declare that all the information provided is true and to the best of my knowledge and I realise that I must inform Vital 24 Healthcare Ltd if there are any changes to any of my information. Any false or misleading information may result in removal from the Vital 24 Healthcare Ltd register of temporary workers.
* I give Vital 24 Healthcare Ltd permission to contact my GP to obtain any further required information.
* I understand that I have to apply for a new DBS Disclosure if required.
* I confirm that I have read the Vital 24 Healthcare Ltd contract of services and fully understand the contents and I have been provided with a copy.
* I declare that under Data protection law, Vital 24 Healthcare Ltd retains the right to keep this application and any other information associated with this application and also to pass it onto any 3rd party. I also agree that Vital 24 Healthcare Ltd can retain the details of my application for employment as long as is reasonably necessary in accordance with the Data Protection Act 1998.
* I declare that I have received a copy of the Vital 24 Healthcare Ltd Staff Handbook and I have read and fully understood its contents within.
* I declare that I am 18 years or older of age and that I am eligible to work in the UK.
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| Signed by Employee |  |
| Print Name |  | Date | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |

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| **HEALTH SELF DECLARATION FORM** |
| Please note: If you falsify any information on this form or fail to mention anything relating to your health which may later come to light, you may be liable for disciplinary action including immediate suspension. |
| 1) Do you have any illness / impairment / disability (physical or psychological) which may affect your work, your own health, safety and welfare, or that of others? Yes No  |
| If you answered yes to the above, please supply details  |  |
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|  |
| 2) Have you ever had any illness / impairment / disability which may have been caused or made worse by your work? Yes No  |
| If you answered yes to the above, please supply details  |  |
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|  |
| 3) Are you having, or waiting for treatment (including medication) or medical investigation at present?  Yes No  |
| If you answered yes to the above, please provide further details of the condition, treatment and dates.  |  |
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| 4) Do you think you may need any adjustments or assistance to help you to do the job?  Yes No |
| If you answered yes to the above, please supply details  |  |
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|  |
| Do you have any of the following? |
| A cough which has lasted for more than 3 weeks? | Yes |  | No |  |
| Unexplained weight loss? | Yes |  | No |  |
| Unexplained fever? | Yes |  | No |  |
| Have you had tuberculosis (TB) or been in recent contact with open TB? | Yes |  | No |  |
| If you answered yes to any of the above, please supply details  |  |
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| As a health care worker, you are under ethical and legal duties to protect the health and safety of the individuals in your care. All information disclosed will be processed in accordance with the requirements of the Data Protection Act |
| Have you ever had chickenpox/varicella? | Yes |  | No |  |
| Can you provide documented evidence of immunity to measles, mumps and rubella? | Yes |  | No |  |
| Have you had a BCG vaccination in relation to Tuberculosis? | Yes |  | No |  |
| Have you ever had a Hepatitis B test in the last 5 years? | Yes |  | No |  |
| If you answered yes to any of the above, please supply details  |  |
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| Please provide the following details of your immunisation record: |

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| --- | --- | --- | --- |
|  | Yes | No | Dates |
| Tetanus |  |  |  |
| Diptheria |  |  |  |
| Poliomyelitis |  |  |  |
| Hepatitis A |  |  |  |
| Hepatitia B (showing titre levels > 100miu/ml) |  |  |  |
| Rubella (German Measles) |  |  |  |
| Varicella  |  |  |  |
| BCG (Tuberculosis vaccination) |  |  |  |

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| I declare that all of the information provided regarding my declaration of health and immunisation record is true to the best of my knowledge and I will endeavour to inform Vital 24 Healthcare Ltd of any changes in my health circumstances that may affect my ability to work. |
| Signed by Employee |  |
| Print Name |  | Date | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |

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| **DOCUMENT CHECKLIST – OFFICE USE ONLY** |

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| --- | --- | --- | --- |
| Candidate Name |  | Qualification / Band |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Document Check** | **Yes** | **No** | **Notes** |
| Application form – fully completed |  |  |  |
| Passport Photo |  |  |  |
| CV (10 Years history, to include Months/Year and no Gaps) |  |  |  |
| Face to face interview record |  |  |  |
| Assessment (Drug calculation or Maths) |  |  |  |
| English Test |  |  |  |
| Personal Identification |  |  |  |
| Work Entitlement (Passport, VISA) |  |  |  |
| Proof of National Insurance (NI, P60, HMRC letter, NHS payslip)  |  |  |  |
| 2 x Proof of Residence |  |  |  |
| Drivers Licence  |  |  |  |
| Marriage Certificate / Deed Poll document |  |  |  |
| Nursing Diploma / Qualifications |  |  |  |
| NMC Statement of Entry |  |  |  |
| NMC Check |  |  |  |
| Occupational Health Clearance Form |  |  |  |
| Mandatory Training & Verification (Including Practical) |  |  |  |
| Employment Contract |  |  |  |
| Fully Enhanced DBS / Update Service (Consent Form) |  |  |  |
| Bank Account Details |  |  |  |
| P45/P46 |  |  |  |
| Indemnity Insurance (RCN/UNISON) |  |  |  |
| Policies and Procedures  |  |  |  |
| ID Badge |  |  |  |
| ID Badge Received confirmation  |  |  |  |
| Health Self Declaration Form completed |  |  |  |
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