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Affix Photograph Here

Application Form

Personal Details	
First Name:	Address:
Surname:	
Maiden Name:	
Marital Status:(Single/Divorced/Married/Widowed):	
Male/Female:	Post Code:
Place Of Birth:	Next Of Kin:
Nationality:	Relationship:
Tel Home: Work:	Contact Number: Email:
National Insurance Number:	

Work Permit	
Do you need a work permit to take up this post:	Yes / No
Working In the UK	
Are you eligible to work in the UK:	Yes / No
Driving Licence	
Do you have a driving licence?	Yes / No
Do you have any Endorsements? If yes, please give details.	Yes / No

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References

Please give names and work addresses of three referees, including telephone numbers, whom we may approach for a reference. **These must be professionals of a senior position to yourself and who have worked alongside you in a Healthcare Setting.**

The first referee should be your present or most recent employer. Relatives are not acceptable.

Name 1:	Designation:
Address:	
Postcode:	
Telephone Number:	Email:
Capacity In which referee knows you:	
Name 2:	Designation:
Address:	
Postcode:	
Telephone Number:	Email:
Capacity In which referee knows you:	
Name 3:	Designation:
Address:	
Postcode:	
Telephone Number:	Email:
Capacity In which referee knows you:	

Employment Information – Please list the last 10 years of your employment (explaining any gaps in employment)

1. Employer Name and Address:	Job Title:
	Location (Ward/Dept):
Date Started:	Email Address:
Date Ended:	Reason for leaving (if applicable):
Telephone:	

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2. Employer Name and Address:	Job Title:
	Location (Ward/Dept):
Date Started:	Email Address:
Date Ended:	Reason for Leaving
Telephone:	
3. Employer Name and Address:	Job Title:
	Location (Ward/Dept):
Date Started:	Email Address:
Date Ended:	Reason for Leaving:
Telephone:	
4. Employer Name and Address:	Job Title:
	Location (Ward/Dept):
Date Started:	Email Address:
Date Ended:	Reason for Leaving:
Telephone:	
5. Employer Name and Address:	Job Title:
	Location (Ward/Dept):
Date Started:	Email Address:
Date Ended:	Reason for Leaving:
Telephone:	

Academic Qualifications

Subjects	Type of qualification e.g. GCSE, Higher, BSc	Grade Achieved

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Professional & Clinical Qualifications & Training

Qualification / Training	Start Date	Grade / Reg No.	Completion Date

Membership Of Professional or Regulatory Bodies

Full Name Of Organisation		Registration Number	Renewal Date

CQC & Government Required Information

Ethnicity

1 = White British
2 = White Irish
3 = Any other white background
4 = Mixed white and Caribbean
5 = Mixed white and black African
6 = Mixed white and Asian
7 = Any other mixed background
8 = Asian or Asian British Indian
9 = Asian or Asian British Pakistani
10 = Asian or Asian Bangladeshi
11 = Asian or Asian British or other background
12 = Black or Black British Caribbean
13 = Black or Black British African
14 = Black or Black British or other background
15 = Chinese
16 = Any other
17 = Prefer not to answer
Code Number……

Religion:	
Sexual Orientation:	

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Asylum & Immigration

I confirm that I have provided the original documentation of two of the following [Circle where appropriate]:

1. Original passport and / or visa
2. Birth Certificate / Marriage Certificate
3. Driver's License
4. P60 / P45 / Current wage slip
5. Proof of Address x 2 (within last 3 months)

Declaration of Service

I can confirm that in my current position that I am / am not undergoing any investigation or suspension in any healthcare organisation or from any professional bodies

Signed: _____ Date: _____

Under the Data Protection Act 1998 I agree to Healthcare Recruiters Limited allowing my personal file to be viewed by the inspection team from the following bodies:

1. The NHS
2. Buying Solutions(NHS PASA)
3. CQC (Care Quality Commission)
4. CPP (Collaborative Procurement Partnership), its Authorities, Representatives, Professional Bodies, Participating Authorities, their Representatives and any relevant Professional Bodies. 5. Any relevant 3rd party bodies

Signed: _____ Date: _____

Rehabilitation Of Offenders Act 1974 (Exemptions Order 1975)

Because the nature of the work for which you are applying involves direct contact with people who are receiving a health service we are obliged to ask you, in connection with this application, to disclose any convictions you may have. Under the conditions of the above order you are not entitled to withhold information about convictions, which might be considered "spent". In the event of employment failure to disclose such convictions could result in dismissal or disciplinary action. Please give details of any convictions you may have on a separate sheet. This information will be treated in the strictest confidence.

I have / have no cautions or convictions to declare:

Signed _____ Date: _____

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Experience Checklist

Please tick all that apply:

Personal Care / Hygiene needs		Paediatrics	
Care of Mouth /teeth/dentures		Dementia	
Care of Nails		Mental Health	
Care of Eyes		Challenging Behaviour	
Continence Care		Learning Disabilities	
Bed Making		Theatre / recovery / HDU / ITU	
Feeding / fluid balance		Immediate post-operative care	
Collection & Testing of specimens		Epilepsy	
Basic Observations & Recording		First Aid / Life Support	
Observing conditional changes		Medication awareness / administration	
Clean Procedures / cross infection		Confidentiality	
Handling / preparation of food		Dealing with Relatives	
Use of moving and lifting aids		Hand over / report writing	
Pressure area care/management		Financial transactions	
Terminal Care / Oncology		Tracheostomy care & management	
Last offices		Suction / Nebulisers / Saturation Level	
Housework / shopping		PEG / Mic-ey care & management	
Detail any other experiences:-			

Payment Details:

Are you operating as a Ltd Company? Yes / No	
If Yes, please provide the Name of your Ltd Company:	
Account Number:	
Sort Code:	

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Declarations

I can confirm that I have read this document fully and that all the information provided to Healthcare Recruiters Ltd is correct and to the best of my knowledge and belief. I give consent to contact referees regarding the information I have provided unless specified otherwise. I will inform Healthcare Recruiters Ltd should anything change that might affect my position and I understand the information given on this form will be processed by computer and used for registration purposes, under the Data Protection Act 1998.

I declare that the information given herein is true and complete and is not presented in a way intended to mislead. I agree that if I have given false or misleading information or omit to give relevant information now or in the future that Healthcare Recruiters Ltd may cease to offer me further agency placements without notice, as well as claim for recovery of any payments I have received, together with a claim for loss of profit to Healthcare Recruiters Ltd.

I acknowledge that my personal details will be stored and handled correctly by Healthcare Recruiters Ltd in accordance with the Data Protection Act 1998, however, I agree that they may be made available for audit/review by relevant third parties. (This is relevant for all information including all documents - DBS, Occupational Health, References).

Signed: _____ Date: _____

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NEW STARTER FORM

SURNAME	FORENAME(S)
TITLE	GENDER
DATE OF BIRTH	NATIONALITY
MARITAL STATUS	EMPLOYMENT START DATE
ADDRESS: POST CODE:	PHONE NUMBER: EMAIL ADDRESS:
NEXT OF KIN DETAILS:	NAME:
PHONE NUMBER:	ADDRESS:
RELATIONSHIP:	POSTCODE
PASSPORT NUMBER	EXPIRY DATE
PIN NUMBER	EXPIRY DATE
DBS NUMBER	ISSUE DATE
NATIONAL INSURANCE NUMBER	TAX CODE

**** ALL LIMITED NURSES NEED TO INCLUDE:-**

-CERTIFICATE OF INCORPORATION OF A PRIVATE LIMITED COMPANY
-LETTER FROM THEIR BANK CONFIRMING THEIR ACCOUNT
-LETTER FROM HMRC REGARDING CORPORATE TAX

BANK DETAILS	Account Number
Account Name:	Sort Code

OFFICE ONLY

NAME OF CONSULTANT	CONSULTANT SIGNATURE
DATE COMPLETED	DATE SENT TO H/O

RECEIVED

BY.....DATE.....

WORKERS PAYROLL NUMBER.....UPDATED

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Healthier Business UK Ltd
OCCUPATIONAL HEALTH

SEQOHS

OCCUPATIONAL HEALTH MEDICAL QUESTIONNAIRE

(NEW STARTER *CLINICAL* FORM)

CONFIDENTIAL

The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake the duties of the post you have been offered or place you at any risk in the workplace. We may recommend adjustments or assistance as a result of this assessment to enable you to do the job. Our aim is to promote and maintain the health of all people at work. Before health clearance is given for employment you may be contacted by Healthier Business UK Ltd and may need to be seen by an occupational health advisor or physician. Your record will be held on file for a short period of time and may be subject to audit. Your file may also be used to cross reference and ascertain your fitness should you register with other clients of Healthier Business UK Ltd.

Title	Surname	First names	DOB

Home Tel:	Work Tel:	Mobile:
Home Address:	GP Address:	

All staff groups complete this section	Yes	No
Do you have any illness/impairment/disability (physical or psychological) which may affect your work?	☐	☐
Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?	☐	☐
Are you having, or waiting for treatment (including medication) or investigations at present? If your answer is yes, please provide further details of the condition, treatment and dates	☐	☐
Do you think you may need any adjustments or assistance to help you to do the job?	☐	☐

Have you suffered from any of the following?	**Yes**	**No**	**Date**
methicillin resistant staphylococcus aureus (**MRSA**)			
clostridium difficile (**C-Diff**)			

If you have indicated YES to any of the above questions you must provide further details in additional information section, failure to do so will result in the form being **returned/rejected**.

Have you ever had chicken pox or shingles		
Yes	**No**	**Date**

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BBV (Blood Borne Virus)		
Have you ever come into contact with any BBV's? Including Needle Stick Injuries?	Yes ☐	No ☐

Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2016)	Yes	No
Have you lived continuously in the UK for the last year (**Include Holidays/ Vacations**)	☐	☐
If you answered NO to the above, please list all of the countries that you have lived in/visited over the last year, including holidays and vacations. This MUST include duration of stay and dates or this form will be rejected.		
Have you had a BCG vaccination in relation to Tuberculosis?	☐	☐
If you answered yes please state when — Date		

Do you have any of the following	Yes	No
A cough which has lasted for more than 3 weeks	☐	☐
Unexplained weight loss	☐	☐
Unexplained fever	☐	☐
Have you had tuberculosis (TB) or been in recent contact with open TB	☐	☐

Have you had any of the following immunisations	Yes	No	Date
Triple vaccination as a child (Diptheria / Tetanus / Whooping cough)			
Polio			
Tetanus			
Hepatitis B (If Yes is ticked please give dates below)			

Course:	1		2		3	
Boosters:	1		2		3	

Varicella	You must provide a written statement to confirm that you have had chicken pox or shingles however we **strongly advise** that you provide serology test result showing varicella immunity
Tuberculosis	We require an occupational health/GP certificate of a positive scar or a record of a positive skin test result **(Do not Self Declare)**
Rubella, Measles & Mumps	Certificate of **"two"** MMR vaccinations or proof of a positive antibody for Rubella and Measles
Hepatitis B	You must provide a copy of the most recent pathology report showing titre levels of 100lu/l or above
Hepatitis B Surface Antigen	Evidence of Hepatitis B Surface Antigen Test (Inc. 'e' antigen and DNA viral loads if applicable Report must be an identified validated sample. (IVS)
Hepatitis C	Evidence of a Hepatitis C antibody test (Inc. Hepatitis C RNA/PCR if applicable) Reports must be an identified validated sample. (IVS)
HIV	Evidence of a HIV I and II antibody test (Inc. DNA viral loads if applicable) Reports must be an identified validated sample. (IVS)

Will your role involve Exposure Prone Procedures	Yes	No

I understand that if any recommendations to my employer are necessary as a result of this Assessment.	
I give consent for the Healthier Business UK Ltd to make recommendations to my employer, without me having seen a written copy of the recommendations first	☐
I would like to see a written copy of any recommendations that Healthier Business UK Ltd may make to my employer before they are sent to my employer.	☐

I will inform my employer if I am planning to or leave the UK for longer than a three month period to enable a reassessment of my health to be conducted on my return. I declare that the answers to the above questions are true and complete to the best of my knowledge and belief.		

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URGENT REFERENCE REQUEST

	Please return at your earliest convenience to: **Vanessa Balogun** **info@padohealthcare.com** **PADO Healthcare Limited** **14, Rosewood Road,** **Manchester** **M9 6QJ**

Applicant Surname:	
Applicant Forename:	
NMC:	
Position Applied For:	

Date:	
Applicant's Position:	

Please provide a written clinical reference addressed to PADO Healthcare including dates of employment, position, responsibilities and any concerns you may have <u>Or</u> complete the below questionnaire

Your name has been provided by the applicant named above, who has applied to PADO Healthcare to be supplied as a locum in the position identified above. We would be grateful if you would reply to the following questions regarding this applicant and provide in confidence any information which you are able to/aware regarding his/her character and suitability to the perform the role and associated duties of the position applied for.

Please provide the following information regarding the applicant named above:

1. Please State/Confirm the most recent dates in which the named applicant worked with you and in what your grade/speciality was at that time					
From (please state month and year)		To		At	
Capacity (Your Position)	☐ Senior Staff Nurse ☐ Team Leader ☐ Clinical Manager ☐ Other Please specify _____				
Did this applicant work directly under your supervision? Yes ☐ No ☐					

2. Do you consider the named applicant suitable for the position identified above? If no, please give details below. *Please tick the relevant box*
Yes ( ) No ( )

3. Do you believe the named applicant to be honest, conscientious and discreet? If no please give details below. *Please tick the relevant box*
Yes ( ) No ( )

In order to protect the public, the post for which the application is being made is exempt from Section 4 (2) of the Rehabilitation of Offenders Act 1974 by virtue of the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975. It is not therefore in any way contrary to the Act to reveal any information you may have concerning convictions which would otherwise be considered as 'spent' in relation to this application and which you consider relevant to the applicant's suitability for employment. Any such information will be kept in strictest confidence and used only in consideration of the suitability of this applicant for a position where such an exemption is appropriate.

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4. Please ✓ as appropriate, providing additional comments in support of the statements made	Excellent	Very Good	Good	Satisfactor	Poor	Unable to Comment
Candidate's Honesty						
Candidate's Reliability						
Candidate's Timekeeping						
Capable of taking responsibility?						
Communication skills?						
Is his/her attendance satisfactory						
Works well under pressure						
Supervisory Skills						

5. Would you re-employ the named applicant? If no, please provide further details below *Please tick appropriate box*
Yes ( ) No ( )

6. Supporting Statement or Written Reference – Please also use this space to let us know of any concerning factors or outstanding complaints regarding the applicants Clinical Ability that you may be aware of.

PLEASE COMPLETE ALL BOXES BELOW

Referee Name		**Position**	
Signature	HANDWRITTEN	**Date**	
Tel No:		**Work E-mail**	
Hospital Name			
Hospital Trust			
Hospital Address			

IMPORTANT

If you are unable to provide us with a stamp, please send us a compliment slip/headed paper with the reference

Your co-operation is much appreciated
PADO HEALTHCARE LIMITED

HOSPITAL STAMP