

**NURSES APPLICATION FORM**

**Please use CAPITAL LETTERS throughout.**

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| --- |
| **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:

Page No: Email Address:

Preferred Contact Method Are you willing to expect morning calls?

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: If yes when do you graduate:

Are you undergoing Adaptation: If yes completion date?

Have your own transport? Type of Transport:

Have you a driving license? If yes any endorsement?

Religion Ethnic Origin

Children under 18 years? Ages

Do you smoke? Yes No Registered Disabled? Yes No

Registration No:

Give details of hobbies/leisure activities

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|  |
| PROFESSIONAL EDUCATION AND TRANING. |

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.**

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| **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 if 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/s for any breaks in employment**

From / / To / / Employer

Address

Telephone: Main contact

Post Title: Grade

Full time or part-time Salary:

Main responsibilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Dept / ward: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for leaving: \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Post Title: Grade

Full time or part-time Salary:

Main responsibilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been dismissed from a job? YES NO

HEALTH DECLARATION

|  |  |  |  |
| --- | --- | --- | --- |
| 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 illness – 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? | YES |  |  |
| 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 Care on Call Nursing Agency 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 PREFERENCE |

**What kind of Nursing Work are you interested in? (Tick all that apply)**

NHS PRIVATE HOSPITAL NURSING HOME

RESIDENTAL 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)

**AVALIBILITY**

From when are you available to work come for an interview?

Do you have any holiday booked? 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, 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 MY NURSING AGENCY CHECKING THE DETAILS I HAVE PROVIDED AGAINST THE VARIOUS DATA SOURCES IN ORDER TO VERIFY MY INDENTITY AND PROCESS THIS APPLICATION. THESE DETAILS MAYBE USE TO ASSIST OTHER ORGANISATION SUCH AS CRB, NMC IN IDENTITY PURPOSES.

SIGNATURE DATED

**REFERENCES.**

Please give the names and addresses of two of most recent employers with work addresses that are able to comment on your work ability and experience. Starting with your present to most recent employer if possible.

(A)

Name of Reference: Company Name

Address:

Postcode: city/ town; country

Telephone no: Fax no:

Email address: Mobile phone:

Start date: / / End date: / / to date

(B)

Name of Reference: Company Name

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_

Postcode: city/ town; country

Telephone no: Fax no:

Email address: Mobile phone:

Start date: / / End date: / / to date

BUILDING SOCIETY /BANK DETAILS

Bank Name

Bank Address

Building Society Bank Roll

Holders Account Name

Sort Code Account No

I authorise My Nursing Agency to pay my weekly wages into the above bank account and I will notify My Nursing Agency 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:  |

WORKING TIME REGULATIONS

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 CRB Disclosure. My Nursing Agency is free to make any other enquiries thy 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 |  |  |
| 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 My Nursing Agency requirements and I are satisfied that this applicant is cleared for work.

NAME OF CONSULTANT

SIGNATURE OF CONSULTANT

DATE

