Nurse/HCA Application Form

WHOLISTIC CARE, HMO & SUPPORTED LIVING
Providing wholistic care to our clients

Please fill each section as required in CAPITAL LETTERS, leave blank if unable to provide any information.

PERSONAL INFORMATION			
TITTLE			
FIRST NAME			
SURNAME			
ADDRESS			
		CITY:	POST CODE:
MOBILE:	HOME:	EMAIL:	
DOB:	ETHNICITY:	NATIONALITY:	
PASSPORT NO.		N I:	

PROFESSIONAL DETAILS		
NMC PIN	PIN EXPIRY:	REGISTER ENTRY:
JOB TITTLE	QUALIFICATION:	DATE GAINED:
DBS NO	EXPIRY DATE	
DBS UPDATE SERVICE NO		

NEXT OF KIN			
Please provide contact details of at least one person we can contact in case of emergency			
NAME			
RELATIONSHIP			
ADDRESS			
		CITY:	POST CODE:
HOME:	MOBILE:	EMAIL:	

BANK ACCOUNT DETAILS	
We pay your wages directly into your bank account weekly	
BANK NAME:	BRANCH:
ADDRESS:	
CITY:	POST CODE:
ACCOUNT NAME:	ACCOUNT NUMBER:
SORT CODE:	LIMITED COMPANY: YES ☐ NO ☐

WORK PREFERRENCES	
Will You Relocate For Work? (With Accommodation)	
Full Time OR Part Time Agency?	
Which Agencies Are Currently Registered With?	
What Shift Pattern Are You Looking For? (Days, Nights, Weekends)	

EMPLOYMENT HISTORY

- ***Please supply details of your work history from school to date***
- ***Please explain any gaps of 2 weeks or more***
- ***CV is acceptable as long as full history with month and years***
- ***Please continue on a different sheet if necessary***

Date From MM/YY	Date to MM/YY	Name and Address of employer	Duties	Band/Grade	Reason for Leaving

PLEASE CAN YOU OUTLINE ANY GAPS IN YOUR EMPLOYMENT HISTORY

EDUCATION HISTORY

- ***Please supply details of your EDUCATION HISTORY***
- ***Please continue on a different sheet if necessary***

Date From MM/YY	Date to MM/YY	Name And Address Of Institution	Qualification	Grade

MANDATORY TRAINING

If you choose yes, please state the date the training was done	Yes	No	Date
Health and Safety at Work			
Control of Substances Hazardous to Health (Inc COSHH & RIDDOH)			
Information Governance (Inc Data protection, Candicott Principles, Information Security, Confidentiality and Record Management)			
Fire Safety Awareness (Theory and Practical)			
Infection, Prevention and Control			
People Moving and Handling (Theory and Practical)			
Basic Life Support with AED (Theory and Practical)			
Safeguarding Vulnerable Adults			
Safeguarding Children (Level 1 & 2)			
Lone Working			
Food Hygiene			
Nonviolent Crisis Intervention (NCI) **OR** Management of Actual Potential Actual Potential OR Conflict Resolution but not limited to Management of Violence and Aggression			

YOUR CLINICAL EXPERIENCE					
Please tick up to 3 boxes to indicate areas you have expertise in					
A&E		Cardiac		Clinics	
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 Homes	
Occupational Health		ODP		Oncology	
Chemotherapy		Orthopaedics		Paediatric A&E	
Paediatrics		Palliative		PICU	
Practice Nurse		Prison		Radiology	
Recovery		Renal		Dialysis	
SCBU		Surgical		Theatre	
Triage		Urology		Walk in Centres	
Other Please Specify					

NEW EMPLOYEE CLINICAL MEDICAL QUESTIONNAIRE

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.

PERSONAL INFORMATION			
Title	**Surname**	**First names**	**DOB**
Home Tel:	**Work Tel:**	**Mobile:**	
Home Address:		**GP Address:**	

MEDICAL HISTORY		
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?		

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

ADDITIONAL INFORMATION

TUBERCULOSIS		
Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006)	Yes	No
Have you lived continuously in the UK for the last year		
If you answered NO to the above, please list all of the countries that you have lived in or visited over the last year. 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:	
Have you had 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		

CHICKEN POX OR SHINGLES		
Have you ever had chicken pox or shingles?		
Yes	No	Date

IMMUNISATION HISTORY								
Have you ever had chicken pox or shingles?								
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			
Booster	1		2		3			

PROOF OF IMMUNITY (Please send the following)	
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 100Iu/l or above
PROOF OF IMMUNITY (Please send the following) EPP Candidates Only	
Hepatitis B Surface Antigen	Evidence of a negative Surface Antigen Test Report must be an identified validated sample. (IVS)
Hepatitis C	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)
HIV	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)

TUBERCULOSIS		
Will your role involve Exposure Prone Procedures?	Yes	No

DECLARATION		
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. I also give consent for the Healthier Business UK Ltd to make recommendations to my employer.		
Name	**Signature**	**Date**

PROFESSIONAL CONDUCT		
Have there been any proceedings of medical negligence or professional misconduct against you?	Yes	No
If yes please supply details		

REHABILITATION OF OFFENDERS ACT		
Because of the nature of the work for which you are applying, Section 4(2), and further orders made by the Secretary of State under the provision of this section of the Rehabilitation of Offenders Act (1974) (Exceptions) Order 1975 applies. Applicants are therefore required to give information about convictions which for other purposes are "spent" under the provisions of the Act. Any information given will be completely confidential and will be considered only in relation for positions to which the order applies		
Have you at any time been convicted of an offence	**Yes**	**No**
If yes please supply details		

Signature	**Date**
Name	

REFERENCE DETAILS
▪ ***Please supply the names and work addresses of at least 2 clinical professional referees a***
▪ ***One must be from your present or most recent employer and must be a senior grade to yourself***
▪ ***One Character reference***
▪ ***The references must cover a period of 3 years in total***

CLINICAL REFERENCE 1	
Name	
Position	
Address	
Daytime Phone	Post Code
Email Address	
Date	
What was your professional relationship with this person?	
From:	To:

CLINICAL REFERENCE 2	
Name	
Position	
Address	
Daytime Phone	Post Code
Email Address	
Date	
What was your professional relationship with this person?	
From:	To:

CHARACTER REFERENCE	
Name	
Position	
Address	
Daytime Phone	Post Code
Email Address	
Date	
What is your relationship with this person?	
From:	To:

DECLARATIONS

1. Compliance

   I understand that I am responsible for ensuring that my personal compliance such as my NMC registration, revalidation, DBS update service and NHS mandatory annual training are kept up to date. If any of these lapse I will be unable to work until I am fully compliant again.

   Signed Date

2. Terms & Conditions

   I confirm that the information given in this application is true I am permitted to work in the UK I understand that my registration is subject to at least two satisfactory references covering three years and enhanced disclosure from the Disclosure and Baring service

   Signed Date

3. Working Time Regulations

   For the purpose of the Working Time Regulations 1998 (as amended), I consent to work in excess of an average of 48 hours per week. I understand that I may withdraw this consent by giving Your Venture Healthcare not less than three months' notice. I understand that my registration with any company within the Your Venture Healthcare group can be terminated at any time following unsatisfactory work reports or complaints

   Signed Date

4. Bank Details

   I confirm that the bank details on this form are complete and correct and that any incorrect or incomplete details can result in a delay of any payments.

   Signed Date

5. Data Protection & Permissions

   I agree that Your Venture Healthcare retains the right to hold this application and any other data required to process it and to pass on to any authorised third party for the purposes of audit and work placements.

   I agree that Your Venture Healthcare can retain these details for as long as reasonably necessary in accordance with the Data Protection Act

   Signed Date

6. Disclosure and Barring Update Service Checks

   I agree that Your Venture Healthcare can access the DBS update service portal to check for any changes to my DBS clearances as and when necessary

   Signed Date

7. Handbook Declaration

   I have received (or downloaded) the company handbook and have understood and will comply with it at all times. I am aware that any amendments or new versions will be available on the appropriate company website.

   Signed Date