

Branch details:

Please attach photograph:

# APPLICATION FORM

## POSITION APPLIED FOR

## PERSONAL DETAILS

(Mr / Mrs / Miss / Ms) Surname:

Forenames:

Full Address:

	Postcode:
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Telephone: Number (home):	Mobile Number:
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Email:

National Insurance Number:

Nationality:

## NEXT OF KIN (to be notified in case of emergency)

Full Name (to include Title, Surname and Forenames):

Full Address:

	Postcode:
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Telephone Number:	Relationship:
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## EDUCATION

*Please provide details of your Secondary Education*

Name of School:

Date of Attendance from:	to:
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## QUALIFICATIONS & GRADES

*Please provide details of your Further Education / Training*

Name of Establishment:

Date of Attendance from:	to:
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## ADDITIONAL / PROFESSIONAL QUALIFICATIONS



## EXPERIENCE QUESTIONNAIRE

To enable us to assess your experience could you please TICK the appropriate boxes

Experience of working in hospitals	<input type="checkbox"/>
- please state areas	<input type="checkbox"/>
-	
-	
-	
-	
Nursing/Residential homes	<input type="checkbox"/>
E.M.I Units	<input type="checkbox"/>
Experience of working in learning disabilities services	<input type="checkbox"/>
Experience of working in mental health services	<input type="checkbox"/>
Experience of working in residential childrens homes	<input type="checkbox"/>
Experience of caring for the terminally ill	<input type="checkbox"/>
Experience of working in youth offending services	<input type="checkbox"/>
Experience of working in a youth club	<input type="checkbox"/>
Experience of working with children with learning disabilities	<input type="checkbox"/>
Experience of caring for those with physical disabilities	<input type="checkbox"/>
Experience of spinal injury care	<input type="checkbox"/>
Experience of acquired brain injury care	<input type="checkbox"/>
Experience of stroke patient care	<input type="checkbox"/>
Experience of caring for people with degenerative conditions	<input type="checkbox"/>
Experience of taking and recording general observations	<input type="checkbox"/>
- please state which i.e. blood pressure, pulse, fluid balance, temperature	
Experience of complex care services - specify below	<input type="checkbox"/>
-	
-	
-	
Any other, please state	

## TRAINING

Please provide the dates that you last undertook the following training courses and provide copies of certificates at interview.

Training Course	Date of Last Training	Training Course	Date of Last Training
Moving & Handling		Administration of medication	
Fire safety		Adult abuse awareness / Safeguarding	
Health & Safety (1974/1999 Acts Including COSHH/RIDDOR)		Food hygiene	
Infection control		Physical Intervention and De-escalation	
B.L.S. / C.P.R.		First aid	
DoLs			

Please give details of any further training, for which, certificates must be provided at interview.

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## TRANSPORT

Do you hold a valid UK Driving Licence? Yes / No Access to a Car? Yes / No

What other forms of transport do you use? \_\_\_\_\_

## OCCUPATIONAL HEALTH

I give consent to Network Healthcare Professionals to have access to any medical/occupational or health records that may be held by you in accordance with the Access to Health Records under the Data Protection Act 1998 (Subject Access Request)

Please confirm you have had the following immunisations and provide recent serology reports:

HEP B Date \_\_\_\_\_

BCG Date \_\_\_\_\_

Rubella, Measles Varicella Date \_\_\_\_\_

### EBOLA

If you, the worker, have been to Guinea, Sierra Leone and Liberia since November 2014 you will be placed into one of the following risk assessment categories:

Category	What this category means
Category 1	This person visited an Ebola affected area, but had no direct contact with an Ebola case (or body fluids) while they were there; this includes people who have had casual contact e.g. visited a home without direct contact with the Ebola patient or body fluids of the patient
Category 2	This person had direct (close) contact with Ebola cases (or body fluids) while they were in the affected area, but wore appropriate protective equipment/clothing (PPE), and had no known breaches in PPE
Category 3	This person had direct (close) contact with Ebola cases (or body fluids) while they were in the affected area, wore appropriate protective equipment/clothing (PPE), but are concerned that they may have had a breach in these protective measures or have had direct contact with an Ebola patient's blood, urine or secretions without being protected

Have you been to one or more of the affected countries on the list above Yes / No

If Yes please state the country, dates of travel and category as listed above

## HEALTH AND DISABILITY

The following questions on Health and Disability are asked in order to find out your needs in terms of reasonable adjustments to access our recruitment service and to find out your needs in order to perform the job or position sought.

Do you have any health issues or a disability which may make it difficult for you to carry out functions which are essential for the role you seek. Yes / No

If you have a disability, what are your needs in terms of reasonable adjustments in order to access this recruitment service and to attend interview, or to take aptitude tests please specify:

## RECORD OF IMMUNISATIONS

(LAB REPORT FROM AN OCCUPATIONAL HEALTH DEPARTMENT OR G.P. PATHOLOGY REPORT CONFIRMING YOUR IMMUNISATION STATUS, IF REQUIRED)

TYPES OF IMMUNISATION	YES	NO	DATES/RESULTS
Rubella (German Measles)			
Measles Disclaimer:- I have / have not had measles.			Signed: _____ Date: _____
Hepatitis B (including Titre levels)			
Antibodies			
Tuberculosis BCG / Scar			
Immuno-deficiency disorders (Inc HIV)			
Varicella - (Chicken Pox / Shingles). Disclaimer:- I can confirm that I have suffered from this disease.			Signed: _____ Date: _____
Tetanus			
Poliomyelitis			

I take full responsibility for entering into employment with Network Healthcare Professionals before completing my full course of inoculations against Hepatitis B. I have been advised and am aware that the inoculations have to be completed, however, the position does not depend on this.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Do you agree to being health screened or to obtaining a certificate of fitness from your G.P. or an Occupational Health Service if required?  Yes  No

## REFERENCES

Please give the names of two professional people, of a senior grade / position to you, including your present or most recent employer, whom we may approach for a reference (not relatives or friends). They must be able to provide a credible comment on your ability to undertake the duties of the post applied for. If the references do not cover the last five years of work, please supply additional referee details on a separate sheet. HOME ADDRESSES OF REFEREES ARE NOT ACCEPTABLE

### REFERENCE 1

Name: \_\_\_\_\_ Position: \_\_\_\_\_  
Name of Establishment / Home: \_\_\_\_\_  
Work Address (not home): \_\_\_\_\_  
Post Code: \_\_\_\_\_ Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_  
How long has this person known you in a professional/work context?  
Was this person senior to you?  Yes  No

### REFERENCE 2

Name: \_\_\_\_\_ Position: \_\_\_\_\_  
Name of Establishment / Home: \_\_\_\_\_  
Work Address (not home): \_\_\_\_\_  
Post Code: \_\_\_\_\_ Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_  
How long has this person known you in a professional/work context?  
Was this person senior to you?  Yes  No

### REFERENCE 3

Name: \_\_\_\_\_ Position: \_\_\_\_\_  
Name of Establishment / Home: \_\_\_\_\_  
Work Address (not home): \_\_\_\_\_  
Post Code: \_\_\_\_\_ Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_  
How long has this person known you in a professional/work context?  
Was this person senior to you?  Yes  No

## PENSION DETAILS

Network Healthcare Professionals are not solely responsible for your workplace Pension. If you are a PAYE worker you will receive a separate communication asking if you wish to opt in or out of our scheme.

If you work via an Umbrella Company it is their responsibility to have a pension scheme for you, please contact them directly. If you work through a Limited Company it is your responsibility to have your own pension scheme.

## PAYROLL INFORMATION

Limited Company (Non Public Sector)	Name of Limited Company
PAYE	P45 or P46 (Please Provide)
Umbrella Company and Contact Details	Name of Umbrella Company:
Please state if you want pay	Weekly <input type="checkbox"/> Monthly <input type="checkbox"/>

## BANK DETAILS

*If your account details are not provided, no payment of wages can be made.*

Account Details

Name of Bank/Building Society:

Address:

Sort Code:

Account Number:

Account in the name of:

*Declaration: I hereby request and authorise Network Healthcare Professionals to credit all amounts due to me to my account, detailed above.*

Signed:

Dated:

## RIGHT TO WORK DETAILS

### Asylum and immigration act 1998

Section 8 of the Act makes it a criminal offence for employers to engage an individual who does not have permission to work within the U.K. Any offer of employment may be subject to you providing evidence of your right to work within the U.K. e.g. National Insurance number, passport or travel document endorsed to permit working in the U.K.

I give permission for Network Healthcare Professionals to contact the Home Office / United Kingdom Immigration Service in order to establish my immigration status and eligibility to work.

Passport:	Location Issued:	Expiry Date:
Right to Work (please state your right to work):		
Visa:	Type:	Expiry Date:

## REHABILITATION OF OFFENDERS

Convictions will not necessarily be a bar to obtaining a post. However because of the nature of the work for which you are applying, this post is exempt from the provisions of Section 42 of the Rehabilitation of Offenders Act 1974. Applicants must declare information about convictions, cautions, reprimands and final warnings, for which other purposes are "spent" under the provisions of the Act.

Have you ever been convicted, cautioned, reprimanded or given a final warning for a criminal offence or are you currently the subject of police investigations?
Are you waiting to hear about any pending prosecutions?
Are you aware of any police enquiries undertaken following allegations made against you, which may have a bearing on your stability for this post?
Have you ever been subject of a disciplinary investigation or proceedings by a previous employer?
If yes to any of the above please supply a written statement

## DBS INFORMATION

### Declaration of Criminal Record and Professional Conduct

#### Criminal Convictions (please circle clearly as appropriate)

Do you have any unspent\* criminal convictions?

Yes / No

Certain types of employment and professions are exempt from the Rehabilitation of Offenders Act 1974 and in those cases particularly where the employment is sought in relation to positions involving working with children or vulnerable adults, details for all criminal convictions must be given. The information given will be treated in the strictest of confidence and only taken into account where, in the reasonable opinion of Pertemps Medical Professionals the offence is relevant to the post to which you are applying.

**Failure to declare a conviction may require us to exclude you from our register or terminate an assignment if the offence is not declared but later comes to light.**

A criminal record will not necessarily be a bar to obtaining a position. Disclosure information will not be used unfairly.

Do you have a current Enhanced Criminal Record Bureau (DBS) Disclosure Certificate?  Yes  No

Current DBS Number..... Expiry Date.....

Is the DBS on the update service Yes / No Issue Date...../...../.....

## DECLARATION - INVESTIGATION / SUSPENSION

Are you currently suspended from duty with any other organisation?  Yes  No

Have you ever been investigated or suspended for a disciplinary or other matter, eg for a referral under safeguarding arrangements?  Yes  No

If 'YES', please provide details and the current investigation status on a separate sheet.

I agree to inform Network Healthcare Professionals if, at any time, whilst registered with them, I am suspended from duty by any other organisation.

Signed:

Dated:

## WORKING TIME REGULATIONS

In line with Government legislation under the terms of "Working Time Regulations" we recommend that your working hours should not exceed 48 hours per week (average over a 17 week period).

Should you wish to waive this right, please confirm below:

I confirm that I would like to opt out of the 48hr working time directive:  Yes  No

(signature required at the end of this document)

## WORKING TIME REGULATIONS

Network Healthcare Professionals are committed to a policy of equal opportunities for all work seekers and shall adhere to such a policy at all times and will review on an on-going basis on all aspects of recruitment to avoid unlawful or undesirable discrimination. We will treat everyone equally irrespective sex, sexual orientation, gender reassignment, marital or civil partnership status, age, disability, colour, race, nationality, ethnic or national origin, religion or belief, political beliefs or membership or non-membership of a Trade Union and we place an obligation upon all staff to respect and act in accordance with the policy.

Network Healthcare Professionals shall not discriminate unlawfully when deciding which candidate/temporary worker is submitted for a vacancy or assignment, or in any terms of employment or terms of engagement for temporary workers. Pertemps Medical Professionals will ensure that each candidate is assessed only in accordance with the candidate's merits, qualification and ability to perform the relevant duties required by the particular vacancy.

## SAFEGUARDING POLICY

**I understand that I must be aware of the prevention of abuse policies I have been advised that Network Healthcare Professionals will retain a copy of these policies and I can access them at any time.**

Signed:

Date:

## CONFIDENTIALITY

Any patient information obtained by you during the course of your duties is confidential and should not be disclosed to any third party if it is not legitimately in connection with their treatment or any other official investigation. Please take care with patient records when on assignment to ensure that they are not in undue danger of being accessed by unauthorised individuals. Patients'/clients' information should only normally be shared with their consent - you should make sure patients'/clients understand that their information may be shared with various members of the team providing care. It is a patient's/client's decision what information should be shared with their family or others. Where a patient/client is considered incapable of giving consent, please consult relevant colleagues. Where a patient/client has withheld consent, disclosures of information may only be made if:

- They can be justified in the public interest (normally where the disclosure is essential to protect the patient/client or someone else from risk of significant harm).
- They are required by law or court order.

You should act in accordance with local and national policies if there is an issue of child protection.

### **Choose how you would like us to use your details**

I agree that Pertemps Network Group may use my personal data to contact me to discuss suitable job opportunities and to pass on my details to potential employers and partner agencies in respect to jobs that may be relevant to me now or in the future.

I give Pertemps Network Group consent to process my information for the purposes detailed above and understand that Pertemps Network Group will enter my details into their central recruitment database.

I understand that my details will be processed in accordance with Pertemps Network Group's Data Processing Policy.

I confirm that I have read and agree to Pertemps Network Group Data Processing Policy.

Please circle as applicable:      Yes / No

I agree that Pertemps Network Group may use my personal data to contact me in relation to services and promotions that may be of interest.

Please circle as applicable:      Yes / No

## DECLARATION

I hereby confirm that the information given is true and correct. I consent to my personal data and CV being forwarded to clients. I consent to references being passed onto potential employers. I consent to my information being made available for the purpose of audit to third parties.

If, during the course of a temporary assignment, the Client wishes to employ me direct, I acknowledge that Network Healthcare Professionals will be entitled either to charge the client an introduction/transfer fee, or to agree an extension of the hiring period with the Client (after which I may be employed by the Client without further charge being applicable to the Client).

I will inform Network Healthcare Professionals immediately of any circumstances that may affect my work, such as changes to health, subsequent pending prosecutions or convictions, which may arise whilst I am registered for permanent or temporary work. I understand that Network Healthcare Professionals has the right to request a Criminal Records Bureau Disclosure and/or credit check where they consider it necessary and that any details from this, or any other police checks provided, may be forwarded to a potential employer.

I give permission for Network Healthcare Professionals to contact a third party for information needed for my file (i.e. Qualification Verification, Training Certificates, Immunisation reports and other documents that require verifying).

**By signing this document, I agree to the statements I have written within this registration document:**

- **Working Time Regulations**                      **Yes / No**
- **DBS Declaration**                                      **Yes / No**
- **Rehabilitation of Offenders Act**              **Yes / No**
- **The Declaration**                                      **Yes / No**
- **Right to Work**    **Yes / No**
- **How we use your details**                          **Yes / No**

Name..... Date .....

Signature.....