Nurses Application form





New Horizons Management Services Ltd

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Email: info@newhorizonservices.co.uk

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**NURSES APPLICATION FORM**

# 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:

Pager No: Email Address:

Preferred Contact Method :

Are You Willing To Expect Morning Calls?: Yes: No:

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?: Yes No If Yes, When Do You Graduate?:

Are You Undergoing Adaptation? Yes: No: If Yes, Give Your

Completion Date:

Have Your Own Transport?: Type Of Transport:?

Have You A Driving Licence? Yes / No If Yes Any Endorsement?

Religion: Ethnic Origin:

Children Under 18 Years? : Yes / No Ages:

Do You Smoke? Yes / No Registered Disabled? Yes No

Registration No:

Give Details of Hobbies / Leisure Activities:

# Professional Education & Training

**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.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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

Are You 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 For Any Breaks In Employment.**

**From: / / To: / / Employer:**

Address:



Telephone: Main Contact:

Post Title; Grade:

Full-time or Part-time: Salary:

Main Responsibilities:





Department / Ward:

Reason for Leaving:



**From: / / To: / / Employer:**

Address:



Telephone: Main Contact:

Post Title; Grade:

Fulltime or Part-time: Salary:

Main Responsibilities:



Department / Ward:



**From: / / To: / / Employer:**

Address:



Telephone: Main Contact:

Post Title; Grade:

Fulltime or Part-time: Salary:

Main Responsibilities:



Department / Ward:

Reason for Leaving:





**From: / / To: / / Employer:**

Address:



Telephone: Main Contact:

Post Title; Grade:

Fulltime or Part-time: Salary:

Main Responsibilities:



Department / Ward:

Reason for Leaving:

# Health Education

|  |  |  |  |
| --- | --- | --- | --- |
| **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** I**f** **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/ 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?  |   |   |   |
| 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 General Response**

**Health and Social Care 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 Preferences

**What Kind Of Nursing Work Are You Interested In? (Tick All That Apply)**

NHS: Private Hospital: Nursing Home: Residential 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):

**Availability:**

From When Are You Available To Work?:

Come For An Interview?:

Do You Have Any Holiday Booked? If yes, 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, not 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 General Response Health and Social Care Ltd Checking The Details I Have

Provided Against The Various Data Sources In Order To Verify My Identity And Process This Application. This Details Maybe Use to Assist Other Organisation Such As DBS CHECKS, NMC In Identity Purposes.

**Signature: Date:**

**References.**

Please Give The Names And Addresses Of Two Of Your Most Recent Employers With Work Addresses Who Is Able To Comment On Your Work Ability And Experience. Starting With Your Present To Most Recent Employer If Possible.

**(A)** Name of Reference:

Company’s Name: Address:



Postcode: City / Town: Country

Telephone No: Fax:

Email Address: Mobile No: Start Date: / / End date: / / To date:

**(B)**

Name of Reference:

Company’s Name Address:



Postcode: City / Town: Country

Telephone No: Fax:

Email Address: Mobile No: Start Date: / / End date; / / To date:

## Building Society /Bank Details

Bank Name:

Bank Address:

Building Society Bank Roll:

Account Holder’s Name; Sort-Code: Account No:

**I authorise General Response Health and Social care Ltd to pay my weekly wages into the above**

**Bank Account and I will notify General Response Health and Social care Ltd** **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 No:

# Working Time Regulations

According To The Working Time Regulations,

1. You are not required to work more than 48 hours per week except agreed in writing.
2. An Agency staff is entitled to 11 hours rest from work in each 24 hours and 12 hours if under 18 years.
3. A minimum of 20 minutes break when the working day is longer than 6 hours.
4. Staff should not work 8 hours in every 24 hours if it is night work.
5. Staff is entitled to a minimum of 1-day rest from work each week or 2 days every 2 weeks.
6. Staff is entitled to 4 weeks paid annual leave once they have worked through a particular agency for a continuous 13 weeks period.

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 DBS

Disclosure.  **General Response Health and Social care i**s Free to Make Any Other Enquiries They 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  |   |   |
| DBS / 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 **General Response Health and Social care** requirements and I am satisfied that this applicant is cleared for work.

**Name Of Consultant:**

**Signature of Consultant:**

**Date:**

**Audit 1**

**Date audit completed:**

**Completed by:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 (office use only)

**REGISTRATION CHECKLIST**

Candidate ……………………. Interviewer …………………………

Position ………………………… Position………………………………

D.O.B. ………………………… Time/Date ……………………………

1. Full face to face interview completed  **YES** [ ]  **NO** [ ]
2. Candidate Communication (Written & oral) Skills checked **YES** [ ]  **N0** [ ]
3. HCA Assessment passed **YES** [ ]  **NO** [ ]

1. DBS Disclosure

 YES [ ]  NO [ ]

 5.COVID -19 Test YES [ ]  NO

 DBS Reference No: ------------------------------------------

1. Copy of valid Passport or Birth certificate if British/Eu National YES [ ]  N0 [ ]
2. Passport photo on file YES [ ]  NO [ ]
3. Own bank details

1. NMC Pin …………………………… Expiration Date ………………………… YES [ ]  NO [ ]

 9. Valid Visa YES [ ]  NO [ ]  N/a [ ]

1. RCN/RCM/Unison Insurance YES [ ]  NO [ ]

1. Signed Terms & Conditions by candidate YES [ ]  NO [ ]
2. Completed and Signed Health Declaration YES [ ]  NO [ ]
3. GP Name and Address YES [ ]  NO [ ]
4. Next of Kin details YES [ ]  NO [ ]
5. Immunisations Date of Immunisation/Test Result/Comments

Polio ------------------- -----------------------

 Tetanus -------------------- --------------------------

 Varicella ----------------------- --------------------------

 TB ---------------------- -------------------------

 Rubella ----------------------- ------------------------

Hepatitis B 1st Jab 2nd Jab 3rd Jab

 ------------- ------------- -------------

 Hep C ---------------- ------------- ------------

 Hepatitis B Certificate YES [ ]  No [ ]

**(Office use only) Date of renewal /update**

**16. Valid Work Permit/ Student Visa** Yes [ ]  No [ ]  ------------------------------------------

17.C & R for people working in Mental Health Yes [ ]  No [ ]  -------------------------------------------

 18. Midwives intention to practice Yes [ ]  No [ ]  --------------------------------------------

19. BLS/ALS (circle appropriate) Yes [ ]  No [ ]  ---------------------------------------

20. Paediatric Advanced Life Support Yes [ ]  No [ ]  -------------------------------------------------

 21. Mandatory Training (Valid) Yes [ ]  No [ ]  ---------------------------------------------------

* First Aid Yes [ ]  No [ ] ------
* Manual Handling Health and Safety) Yes [ ]  No [ ]  ----- Infection Control Yes [ ]  No [ ]  ----
* Clostridium Difficle & MRSA Yes [ ]  No [ ]  ----
* Lone Work Yes [ ]  No [ ]  -----

 Caldicott Protocols

* Handling patient information, Yes [ ]  No [ ]  --------
* Risk Incident Reporting Yes [ ]  No [ ] --------
* Complaints Handling Yes [ ]  No [ ] --------
* Manual Handling Operations Regs Yes [ ]  No [ ]  -------
* Practical Manual Handling Yes [ ]  No [ ]  ------
* Usage Practices Yes [ ]  No [ ] -------
* Principles of Hoist Training Yes [ ]  No [ ] -------
* Adult Life Support (HSE Recognised) Yes [ ]  No [ ] ------
* Basic food Hygiene Yes [ ]  No [ ]  -----

 **ACTION & RESPONSE**

**Verbal references requested 1. Verbal Date--------- 2 Verbal Date ------------------**

**Written references received 2. Written Date --------- 2 Written Date:---------------**

NMC Online registration confirmation Date: ------------ Result ---------------------

 (Office use only)

**INTERVIEW NOTES:**

Form completed by:------------- Signature: -------------------------------- Date: -------------------------