

APPLICATION FORM

PLEASE COMPLETE THIS FORM
FULLY AND LEGIBLY IN BLOCK
CAPITALS.

POST APPLIED FOR:

NURSE

HEALTH CARE ASSISTANT

PERSONAL DETAILS

MR/ MRS/ MISS/ MS (DELETE AS APPROPRIATE)

FIRST NAME

LAST NAME

OTHER NAMES

DATE OF BIRTH

MAIDEN NAME

No. & AGES OF CHILDREN

ADDRESS

POST CODE

TEL No. (HOME)

MOBILE No

EMAIL ADDRESS

TRANSPORT CAR / PUBLIC / OTHER (Delete as applicable)

NATIONALITY:

RELIGION:

WORK PERMIT: YES / NO

EMERGENCY CONTACT

NAME:

RELATIONSHIP:

TEL NO. (HOME):

(WORK):

PIN NUMBER: (TRAINED STAFF ONLY)

DATE OF EXPIRY:

NATIONAL INSURANCE NUMBER

ARE YOU INTENDING WORKING FOR THE AGENCY ONLY OR IN ADDITION TO YOUR PRESENT WORK ?

WOULD YOU PREFER ?

DAY

EVENING

NIGHTS

WEEKENDS

APPROXIMATE NUMBER OF HOURS PER WEEK ?

QUALIFICATION RECORD (INCLUDING SHORT COURSES ATTENDED)		
Name of Training School	Dates of Training	Qualification Gained

EMPLOYMENT RECORD (MOST RECENT FIRST) Continue on separate paper if necessary		
NAME AND ADDRESS OF EMPLOYER		
TIME IN PRESENT EMPLOYMENT	FROM	TO
POSITION HELD		
REASON FOR LEAVING IF APPLICABLE		

NAME AND ADDRESS OF EMPLOYER		
TIME IN PRESENT EMPLOYMENT	FROM	TO
POSITION HELD		
REASON FOR LEAVING		

REFERENCES WILL BE REQUESTED IF YOU ARE SELECTED FOR INTERVIEW.	
Please provide details of two persons whom we may approach for a reference. These should be your current and previous employers.	
NAME OF REFEREE	NAME OF REFEREE
ADDRESS	ADDRESS
TEL No:	TEL No:
OCCUPATION/POSITION	OCCUPATION/POSITION

**ALLCARE NURSES AGENCY
LTD
EMPLOYEE DECLARATION**

Due to the nature of the work involved, you are required to answer / authorise the following :-

REHABILITATION OF OFFENDERS ACT HEALTH AND SOCIAL SERVICES EXEMPTIONS

This post is exempt from the provision of Section 4(2) of the Rehabilitation Of Offenders Act 1974 by virtue of the Rehabilitation Offenders Act 1974 (exemptions Order 1975). You are therefore not entitled to withhold information about convictions which, for other purposes, are "spent" under the provision of the Act, and in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action by Allcare Nurses Agency Ltd. Any information given will be completely confidential and will be considered only in relation to any application for posts to which the Order applies.

- 1.a) Have you ever been convicted or cautioned of a criminal offence? YES / NO
(Other than minor traffic offences e.g. parking tickets)

- b) If so, please give details.

- 2. Are there any criminal proceedings pending against you? YES / NO

DISCIPLINARY HISTORY

- 1.a) Have you ever been disciplined or asked to resign by your current or previous employer? YES / NO

- b) If so, please give details.

CONFIDENTIALITY

All information etc., which you may see or hear in the course of your duties is confidential. You may not disclose to any other person any details or information relating to the clients, their medical conditions or Company matters.

I understand this to be a condition of my employment with Allcare Nurses Agency Ltd.

I confirm that I have read and understood the above and that the information I have given is correct.

Signature

Date

Please return this form to : **Allcare Nurses Agency Limited**
Allcare House
31 Wellington Street (St John)
Blackburn
BB1 8AF **Tel: 01254 682200**

Health questionnaire to be completed before interview.

The purpose of this questionnaire is to discuss whether you are suffering from any medical condition or are undergoing any medical treatments such as those listed below that may affect your fitness to work.

Name	
Address	
Date	Signature

	HAVE HAD	NEVER HAD	DETAILS
Back Related Problems			
Muscular Strain			
Joint Problems i.e. Arthritis			
Physical Disabilities			
Diabetes			
Heart and Lung Problems -			
For example :- Angina			
Chronic Bronchitis			
High Blood Pressure			
Asthma			
Stomach & Bowel Disorders			
For example :- Ulcers			
Stomas			
Hernias			
Epilepsy, Fainting Attacks			
Skin Problems			
For example :- Dermatitis			
Psoriasis			
Skin Allergies			
Kidney Problems			
Psychiatric Illness			
For example :- Anxiety			
Depression			
Migraine			

Date of last chest X-ray _____ Was is clear? Yes No

Please enter your :

Height _____ Weight _____

Have you had or do you still have any other illness not mentioned above? If yes, please give details

Have you had or do you still have any infectious disease, e.g. Hepatitis A, B or C, HIV, MRSA? If yes please give details.

Do you smoke?

Do you take any drugs other than prescribed by a Doctor?

How many units of alcohol do you drink per week?
(1 unit = 1 glass of wine or 1 measure of spirits or 1/2 pint beer)

Have you done any shift work before?

Have you had any problems associated with this? If yes please give details

Do you think you will be able to cope with night work?

Do you have any sleep problems?

Are you on any medication/treatment?

Have you had any major operations illnesses not already mentioned?

Have you any problems with hearing or vision?

Is there anything else you wish to bring to our attention? If Yes, Please give details.

How many days sickness have you had in the last two years?

To the best of my knowledge this information is correct. I understand that the company reserves the right to withdraw any offer of appointment or to terminate employment already commenced if the information given by me is inaccurate. I consent to you contacting my General Practitioner for further information.

Signed Date

GP

Address

Please complete, sign and date this form. Take this form to your Doctor and ask for it to be stamped, or provide evidence (by certificates) that this is an accurate record.

I (insert name) _____ certify that this is an accurate statement of my vaccination and immunisation record and should be included in my personal file.

Signed: _____

Dated: _____

HEPATITIS B DATE BOOKED
DATE IMMUNISED: 1 2 3

HEPATITIS B ANTIBODIES DATE TESTED:
RESULT: if Titre levels over 100 no further action needed
FURTHER ACTION NEEDED

Diphtheria and tetanus are now given as a joint inoculation and should be renewed every 10 years. With tetanus if you have had 3 in your lifetime it does not need renewing unless you have a serious injury where the risk increases.

TETANUS / DIPHTHERIA DATE IMMUNISED:

Polio should be renewed every 10 years.

POLIO DATE IMMUNISED

Rubella : if you have not had rubella and have not been vaccinated then you will not be allowed to work in certain areas.

RUBELLA (GERMAN MEASLES) DATE IMMUNISED DATE HAD

Tuberculosis is once in a lifetime immunisation, unless you are at risk. All staff should have been immunised. If you have not been immunised then you must have a test to check immunity.

TUBERCULOSIS (BCG) DATE IMMUNISED RESULT OF TEST SCAR SEEN
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Varicella : if you have not had chicken pox and or shingles and are not immunised you will not be able to work for the agency.

VARICELLA / SHINGLES DATE IMMUNISED DATE HAD

GP NAME _____

GP ADDRESS _____

G.P. STAMP (if unable to provide certificates or other evidence)
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Training needs are highlighted in all legislation now and whilst we realise that many of you do regular updates of training needed, in your own place of work, we do need evidence to prove this. Therefore we have listed the training requirements for you to fill in.

Our induction course is of four to six days duration, dependent upon individual needs, and will be completed by all new staff unless they can prove competency. All the courses run from 0930 to 1600 each day. Details of the courses will be given at interview.

INDUCTION DAY ONE (mandatory) this will include the company policy and procedures, and completion of staff records.
 INDUCTION DAY TWO if needed, will include the basic principles of care and client needs.

INDUCTION DAY THREE if needed, will include intermediate principles of care

FIRST AID & BASIC LIFE SUPPORT (mandatory) DATE DONE _____

MOVING AND HANDLING AWARENESS (mandatory) DATE DONE _____

HEALTH AND SAFETY (mandatory) DATE DONE _____

We also provide other courses which enhance your personal professional development. Further details of these courses can be given at interview.

OTHER TRAINING COURSES ATTENDED:

COURSE ATTENDED	DATE ATTENDED

I (insert name) _____ certify that this is an accurate record of my training completed to date and should be entered into my file. I also agree that if I cannot provide evidence I will attend the mandatory training before commencing work, and at least once every twelve months whilst working for the agency.

Signed _____

Dated _____