Third Hard Healthcare Limited
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APPLICATION FORM FOR RGN/RMN

Section 1 – Personal Details

Title: Mr/Mrs/Miss/Ms Surname:

Forenames: Any other Surnames

Date of Birth: Likes to be known as

Nationality: Work Permit No:(if applicable)

Full Address:

Post Code

Email address: Telephone No. (Daytime)

Mobile No: Is it convenient to telephone you at work: Yes/No

Email :

Have you recently been resident outside the UK YES ☐ NO ☐

National Insurance No:

Do you hold a current full driving license? YES ☐ NO ☐ Do you have a car available? YES ☐ NO ☐

Next of Kin (To be notified in case of Emergency)

Name:

Address:

Tel No: Relationship:

	Written	Spoken

Language Language						
	Written			Spoken		
	Fluent	Good	Fair	Fluent	Good	Fair

EDUCATION – including Further Education

Name of School or Institution	Details of Course Taken	Date From	Date To	Qualifications Gained

PROFESSIONAL QUALIFICATIONS

Please list below any courses/studies undertaken during the last five years which may be relevant to nursing

Title of Course	Brief Description of Course	Course Date

Pin Number_____________________________ Expirey Date____________________________________

Please tick appropriate grade

GRADE: D **GRADE: E** **GRADE: F** **GRADE: G**

EMPLOYMENT HISTORY (most recent first)

Please give full details of all your employment history, in reverse date order including the month, starting with your present position & continuing on a separate sheet if necessary, including all work employment abroad and any gaps in your employment which must be explained.

Reference 1 Professional reference

Name and Address of Employer	Position	Date From	Date To	Grade	Reasons for Leaving

Name: Qualification:

Position held by Referee: Date of Employment:

Work Address (not home)

Telephone: FaxNo:

Reference 2

Name: Qualification:

Position held by Referee: Date of Employment:

Work Address (not home)

Telephone: FaxNo:

Rehabilitation of Offenders Act 1974

By virtue of the Rehabilitation of Offenders Act 1974 (Exemptions) (Amendments) Order 1986, the provisions of section 4.2 of the Rehabilitation of Offenders Act 1974 **do not apply** to any employment which is concerned with the provisiion of health services and which is of such a kind to enable the holder to have access to persons in receipt of such services in the course of his/her normal duties. Your answer to the following question MUST include any 'spent' convictions.

Have you ever been convicted of a criminal offence? YES/NO Signature:

If you have answered 'yes' please attach details including dates on a separate sheet.

Working Time Directives

The European Union has laid down guidelines for all workers, governing the length of the maximum working week that it is safe to work. The current limit is 48 hours per week. Because you are under no obligation to accept work offered, you will never be compelled to work more than 48 hours per week but you may choose to do so.

Please would you sign below to confirm that you have read and understood this information, including your preference by **ticking the most appropriate box**.

I DO NOT wish to work more than 48 hours per week	☐
I DO wish to work more than 48 hours per week	☐

Signed X Date

Data protection Act 1998 and Inspection

Part of the Care Standards Commission inspection and other local accredited bodies process involves checking that we maintain certain information on staff e.g. address, qualifications, a mechanism for checking health and fitness including records of immunisation, record of training, annual leave and sickness, two written references and Rehabiliation of Offenders information. Inspectors will need to know that the Company is maintaining the information as we should; please be assured that they will not wish to read personal information such as supervision notes.
We would therefore be grateful if you would complete and sign the declaration box below. If you have any concerns about this or want to discuss it further, please contact your branch manager.

I consent/do not consent (circle as appropriate) to staff from the local registration and Inspection Unit have access to information held on my personal file for inspection purposes.

Print Name:

Signed: X Date

Experience Questionnaire

Qualified Nurses Experience Checklist. Could you please TICK the appropriate boxes in order to define the areas in which you have experience.

A&E		Occupational Health	
Anaesthetics		ODA/ODP	
Burns & Plastic		Oncology	
Cardio Thoracic		Opthalmics	
CCU		Orthopaedic	
Dental Nursing		OutPatients	
Dermatology		Paediatric ICU	
Disabilities		Paediatric	
District Nursing		Phlebotomy	
ENT		Practise Nursing	
Family Planning		Psychiatry – Acute	
Genito Urinary		- EMI	
Elderly Care		- Long Stay	
Gynae		- Forensic	
Haematology		Radiography	
Industrial		Recovery	
Infection Control		Renal Dialysis	
ITU/ICU		SCBU	
Learning Disability		Screening	
Challenging Behaviour		Social Work	
MRI Unit		Surgical	
Medical Care		Terminal Care	
Medical		Theatre	
Midwifery		Tropical Diseases	
Nanny		X ray	
Neurology			

The information that I have given in this registration form is, to the best of my knowledge, complete and accurate in all respects. I understand that knowingly giving false information will disqualify me from registration with the agency. I also agree to keep **All Care (GB) Limited** advised of any changes to any of the information supplied.

Print Name: Qualification:

Signed: X Date

Please ensure you include the following documentation with your completed registration form in the envelope provided.
NB. Please note that if you send photocopies, original documents must be brought with you on interview so consultants can sign photocopies as ('original seen')
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Document required	Tick box if enclosed
2 passport photographs	
Proof of Indentify (birth, marriage cert. or new style driving license photocard, passport)	
Copy of work permit, visa stamp and entry stamp in your passport for oversea applicants	
Completed abilities form	
Valid lab report or letter from doctor regarding your immunisation status	
Relevant certificates of training	
Proof of national Insurance Number	
A copy of your CRB certificate or your completed CRB form & relevant original documentation	
PIN Number	
RCN Card or Insurance details	

Health questionnaire

Please answer all of the questions	**Yes**	**No**	**Additional info to "yes" response**
Have you ever suffered from any of the following:			

Tuberculosis, Asthma, Bronchitis, German Measles, Typhoid, Dysentery, Poliomyelitis, Rheumatic Fever, Jaundice, Hepatitis, Chickenpox			
Chest Pain, Heart condition or raised blood pressure			
Epilepsy, fits, attacks of giddiness, migraine			
Depression, mental illness or nervous breakdown			
Diabetes, thyroid or other gland trouble			
Dermatitis, skin allergies, psoriasis or eczema			
Back injury, back problems or back pain			
Gastric problems, ulcers, irritable bowel syndrome			
Varicose veins, circulatory problems			
Poor eyesight. Do you wear glasses, lens			
Hearing problems, ear infections			
Have you any reason to believe you may be infected by any communicable disease? Have you ever had salmonella or food poisoning? Have you ever suffered from or come into contact with Hepatitis B?			
Have you recently been resident outside of the UK			
Are you currently receiving treatment or medication?			
Have you ever had any major operations or illnesses?			
Approx. how many days' sickness or absence have you had in the last 12 months?			
Are you in receipt of a disability pension?			
Are you registered under the Disabled Persons Act?			
Have you ever been deemed medically unfit for any reason?			
Do you smoke? What is your weight and height			
How many units of alcohol do you drink per week? (1 unit = ½ pint beer= 1 glass of wine=1 single whisky)			

Have you ever been vaccinated, immunised or tested for/against any of the following:

Types of immunisation	Yes	No	Date / Results
Tetanus			

Diphtheria Schick tests			
Rubella			
Poliomyelitis			
Hepatitis B			
Antibodies			
Tuberculosis (BCG)			
Chest X-ray			

I declare all of the statements are true and complete to the best of my knowledge and belief
Signed……………………………......... Date…………………………...

I……………………………………………..give permission to All Care (GB) Limited to contact my GP for clarification of further information on my health status if required.
Name of GP……………………………………………………………………….
Address………………………………………………………………………….
Tel No…………………………………………………………………………..

For night shift workers only
Have you ever worked night shifts before?
What type of work was this?
How long have you been working night shifts?
Have you ever suffered health problems directly related to working night shifts?

Statement of fitness for work for official use only

Date of assessment……………………………. Annual review date…………………………
Assessment undertaken by……………………………………………………………………….
Qualifications……………………………………………………………………………………….

I declare that I have answered the above questions honestly and fully and I am not aware of any physical or mental disability which will, or may, affect my working capacity. I realise that any false or incomplete statement on my part will render me liable to disciplinary action or dismissal. I also declare that I have read the Conditions of Membership attached and agree to abide by their conditions.

I also understand that my details may be submitted for a police check in relation to the Child Protection legislation.

Signed: X Date