8B Station Road |New Milton|BH25 6JU.
Tel:01425204669 |Mob: 07474719869
Email: info@relycare.co.uk |Web: www.relycare.co.uk

NURSES APPLICATION FORM

Please use CAPITAL LETTERS throughout.

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:_____
Page No:_____ Email Address:_____
Preferred Contact Method:_____ Are you willing to expect morning calls? _____
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?_____ If yes when do you graduate?_____
Are you undergoing Adaptation?_____ If yes completion date:_____
Have your own transport?_____ Type of Transport?_____
Have you a driving license?_____ If yes any endorsement?_____
Religion:_____ Ethnic Origin:_____
Children under 18 years?_____ Ages:_____
Do you smoke? Yes ( ) No ( ) Registered Disabled? Yes ( ) No ( )
Registration No: _____
Give details of hobbies/leisure activities:_____

_____

_____

_____

_____ .....

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PROFESSIONAL EDUCATION AND TRANING.

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				

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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 if 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: ____

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Employer's Address: _____

Telephone: _____ Main contact: _____
Post Title: _____ Grade: _____
Full time or part-time: _____ Salary: _____
Main responsibilities: _____

Dept. / ward: _____
Reason for leaving: _____

From: ____/____/____ To: ____/____/____ Employer: _____
Employer's Address: _____

Telephone: _____ Main contact: _____
Post Title: _____ Grade: _____
Full time or part-time: _____ Salary: _____
Main responsibilities: _____

Dept. / ward: _____
Reason for leaving: _____

From: ____/____/____ To: ____/____/____ Employer: _____
Employer's Address: _____

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Telephone:_____ Main contact:_____
Post Title:_____ Grade:_____
Full time or part-time:_____ Salary:_____
Main responsibilities:_____

Dept. / ward: _____
Reason for leaving: _____

From:____/____/____ To:___/____/____ Employer:_____
Employer's Address: _____

Telephone:_____ Main contact:_____
Post Title:_____ Grade:_____
Full time or part-time:_____ Salary:_____
Main responsibilities:_____

Dept. / ward: _____
Reason for leaving: _____

From:____/____/____ To:___/____/____ Employer:_____
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Full time or part-time:_____ Salary:_____
Main responsibilities:_____
_____
_____
_____
Dept. / ward: _____
Reason for leaving: _____
_____
_____
_____
_____

Have you ever been dismissed from a job? YES NO

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HEALTH DECLARATION

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 if 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 illness – 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?	YES		
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.			

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I certify the above information is correct and hereby give permission to RELY CARE LIMITED 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 PREFERENCE

What kind of Nursing Work are you interested in? (tick all that apply)

NHS:_____PRIVATE HOSPITAL:_____NURSING HOME:_____

RESIDENTAL 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):_____

AVALIBILITY

From when are you available to work:_____Come for an interview:_____
Do you have any holiday booked?_____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, 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…… .

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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 MY NURSING AGENCY CHECKING THE DETAILS I HAVE PROVIDED AGAINST THE VARIOUS DATA SOURCES IN ORDER TO VERIFY MY INDENTITY AND PROCESS THIS APPLICATION. THESE DETAILS MAYBE USED TO ASSIST OTHER ORGANISATION SUCH AS CRB, NMC IN IDENTITY PURPOSES.

SIGNATURE _____ DATED _____

REFERENCES.

Please give the names and addresses of two of 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 Name: _____

Address: _____

_____

_____

Postcode: _____ City/Town; _____ Country _____

Telephone No: _____ Fax No: _____

Email address: _____ Mobile phone: _____

Start date: ____/____/____ End date: ____/____/____ To date: ____/____/____

(B)

Name of Reference: _____ Company Name: _____

Address: _____

_____

_____

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Postcode:_____City/Town;_____Country_____

Telephone No:_____Fax No:_____

Email address:_____Mobile phone:_____

Start date:____/____/____ End date:____/____/____ To date: ____/____/_____

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BUILDING SOCIETY /BANK DETAILS

Bank Name: _____
Bank Address: _____
_____
_____

Building Society Bank Roll: _____
Holders Account Name: _____
Sort Code:_____Account No:_____

I authorise My Nursing Agency to pay my weekly wages into the above bank account and I will notify My Nursing Agency 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: _____

WORKING TIME REGULATIONS

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 CRB Disclosure. My Nursing Agency is free to make any other enquiries thy may find necessary

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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		
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 My Nursing Agency requirements and I am satisfied that this applicant is cleared for work.

NAME OF CONSULTANT: _____

SIGNATURE OF CONSULTANT: _____

DATE: _____