**APPLICATION FORM**

Please Complete Application in BLOCK CAPITALS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Position Applied For:** ....................................................................................................... | | | | | |
| Title: | Mr Mrs  Miss Ms | Forename(s): |  | Surname: |  |
| Address: |  |  | Date of Birth:  Gender:  NI Number: | Age: | Telephone Numbers:  Home:  Mobile: |
| Email: |  |  |  |  |  |

|  |
| --- |
| If you do not hold a British/EU Passport, do you have any one of the following? |
| Student Visa |
| Work Permit |
| Residency Visa |
| Spousal Visa |
| Settlement |
| Other: |
| Expiry Date: |

**Work Requirements**

|  |  |
| --- | --- |
| Are you an EU Citizen? | Yes  No |
| Do you hold a British or EU Passport? | Yes  No |

|  |
| --- |
| Do you hold a current Driving Licence? YES/NO  Do you have access to a car? YES/NO |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How far are you willing to drive? | 10-20 miles | 20-30miles | 30-40miles | 40-50miles | 50+ miles |

**Education**

|  |  |  |
| --- | --- | --- |
| Name(s) of School/College | Date(s)  From To | Qualification(s) Gained/Award |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Rehabilitation of Offenders Act 1974**

Please Note: All healthcare posts are subject to the Rehabilitation of Offenders Act 1974; therefore you must disclose all cautions, reprimands, final warnings and convictions on your criminal record. However, a conviction will not necessarily restrain you from employment.

Have you ever been convicted by the courts, cautioned, reprimanded or given a final warning

by the police?  **YES/NO**

If **YES**, please give details including dates: .............................................................................................................

.................................................................................................................................................................................

Are you aware of any police enquiries being made against you that may affect your suitability for this post? **YES/NO**

If **YES**, please give details: ..........................................................................................................................................

....................................................................................................................................................................................

**Next of Kin/Emergency Contact Details**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | | |
| Name: |  |  |  |  |  |
| Address: |  |  | Relationship:  Mobile:  Email: |  |  |
|  |  |  |  |  |  |

**Registered Nurses**

Did you qualify in your maiden name? **YES/NO** Maiden Name: ..............................................................................

Part of Register and Grade: ..........................................................................................................................................................

Date Qualified: ........................ NMC PIN Number: .......................................................... Expiry Date: ............................

Do you have Professional Indemnity? **YES/NO** Membership Name & Number: ...............................................................

**Work Preference**

Are you a Limited Company? Yes/No (Please provide appropriate documentation)

Full Time Part Time Mornings Evenings

Weekends Bank Holidays Nights Sleep In

Have you ever been dismissed from work? **YES/NO**

If **YES**, please explain ........................................................................................................................................

...............................................................................................................................................................................

Have you ever been disciplined for any cause in your last employment? **YES/NO**

If **YES**, please explain ........................................................................................................................................

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**Employment History**

Please enter ALL your previous employment details giving reasons why you left. Please give reasons for any gaps in employment. Start with the most recent employment.

|  |  |  |  |
| --- | --- | --- | --- |
| **Position:** | **Name of Company/Organisation** | **From/To** | **Reasons for Leaving** |
|  |  |  |  |

**Trainings**

Please tick (√)

Health & Safety Moving & Handling First Aid

Urinalysis Food Hygiene Infection Control

12 Lead ECG Vital Observations MVA

MAPPA Fire Safety Safeguarding

NVQ Level 2 NVQ Level 3 NVQ Level 4

Rescue Medication Medicine Management Basic Life Support

**Other Trainings and Professional Qualifications:**

|  |  |  |  |
| --- | --- | --- | --- |
| Qualification | Place were obtained | From (month/year) | To (month/year) |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

(Please provide documentary evidence of all the above – all certificates will be verified)

Where did you hear about Quality Healthcare Agency?

Quality Healthcare Agency website Job Centre Indeed Other

If other, where?..........................................................................

**References**

Please give the names and addresses of 2 professional referees, both of whom should be your current/previous line manager(s) and who have known you for at least 2 years. Relatives are not acceptable as referees.

|  |
| --- |
| 1. Name: Company: |
|  |
| Address: Relationship to You: |
|  |
| Telephone Number: |
|  |
| Fax Number: |
|  |
| Email Address: |
|  |

|  |
| --- |
| 2. Name: Company: |
|  |
| Address: Relationship to You: |
|  |
| Telephone Number: |
|  |
| Fax Number: |
|  |
| Email Address: |
|  |

Please give the name and address of 1 character reference (preferably a work colleague)

|  |  |
| --- | --- |
| 3. Name: | Relationship to You: |
| Address: | Telephone Number:  Email Address: |

**Declaration**

*All applicants please read carefully and sign*

I declare that the information given in this application is accurate and complete. I understand that any misleading statements may be sufficient to cancel any offer of employment or may result in the immediate termination of my employment. Due to the nature of the duties I will be expected to undertake, it is my responsibility to declare any criminal convictions, reprimands, cautions, NMC suspensions, removal from the register, warnings as to future conduct both before and after any employment with Quality Healthcare Agency. This includes any referral to, or inclusion to POVA, or any such scheme currently existing or that comes into effect during my employment with Quality Healthcare Agency. I will declare any dismissals or disciplinary acts from any previous employment. I do understand that any offer of employment is subject to an Enhanced DBS check, indicating my suitability for employment.

**Signature: Date:**  / /

**Print Name:**

**\*Please attach your current CV with this application Form\***

**Clinical Details & Work Experience**

To be completed by all nurses and support/care staff. Please tick (√) the appropriate.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Less than 6 months | More than 6 months | Over 1 year experience | When did you last work?  Please add notes if necessary. |
| General Nurse: |  |  |  |  |
| Medical |  |  |  |  |
| Surgical |  |  |  |  |
| Elderly Care |  |  |  |  |
| Gynaecology |  |  |  |  |
| Orthopaedics |  |  |  |  |
| Palliative Care |  |  |  |  |
| A & E |  |  |  |  |
| Oncology |  |  |  |  |
| ITU/HDU/CCU |  |  |  |  |
| Renal/Urology |  |  |  |  |
| Cardiology |  |  |  |  |
| Neurology/Respiratory/COPD |  |  |  |  |
| Theatre |  |  |  |  |
|  |  |  |  |  |
| Mental Health: |  |  |  |  |
| Mental Health Acute Wards |  |  |  |  |
| Community Psychiatric Nurse |  |  |  |  |
| Elderly Care |  |  |  |  |
| Substance Misuse |  |  |  |  |
| Eating Disorder |  |  |  |  |
| CAMHS |  |  |  |  |
| Prison |  |  |  |  |
| Secure Units |  |  |  |  |
|  |  |  |  |  |
| Learning Disability: |  |  |  |  |
| Autism Spectrum |  |  |  |  |
| Brain Injury |  |  |  |  |
|  |  |  |  |  |

**Equal Opportunities Monitoring Form**

Quality Healthcare Agency aims to select applicants solely based on merit irrespective of age, gender, sexual orientation, marital status, disability, religious beliefs, nationality and/or ethnic origin. The following information will be held in confidence and will be used for monitoring purposes only. It will not be considered during our recruitment and selection process.

*Please tick (√) the most appropriate*

|  |
| --- |
| Gender |
| Male Female |
| Ethnic Origin Disabilities |
| 1. White Do you have any disabilities? YES/NO   British If YES, please give details below: ...............................  Irish ....................................................................................  Other (specify) ....................................................................................  ....................................................................................   1. Mixed   White & Black Caribbean  White & Black African  White & Asian  Other (specify) Do you require Quality Healthcare Agency to make  any reasonable adjustments under the terms of  the Disability Discrimination Act for you to   1. Asian or Asian British undertake the duties of this post? YES/NO   Indian If YES, please give details below: ...........................  Pakistan .................................................................................  Bangladeshi .....................................................................................  Other (specify) .....................................................................................     1. Black or Black British   Caribbean  African  Other (specify)   1. Oriental or Other   Chinese  Japanese  Philippine  Other (specify) |
|  |

**PLEASE PROVIDE THE FOLLOWING DOCUMENTS ALONGSIDE WITH YOUR APPLICATION**

2 X Passport sized photos

Proof of ID – Passport, Driving License, UK Birth Certificate

Proof of Address – Utility Bill, Bank Statement, Council Tax Letter, and etc.

Proof of NI – P45, P60, HM Revenue Award Letters, DWP Award Letters and etc.

Evidence of Trainings – Certificates, Letterhead and stamped Letter from previous employer stating trainings

Evidence of Vaccinations – Health Record Book, Letter from GP stating current vaccinations

DBS Update Service Ref. Number (If registered with the Update Service) otherwise,

Provide Addresses where you have lived in the last 5 years

***Any letters provided should be dated within the last 3 months, except annual award letters e.g. HM Revenue and DWP award letters***

**PLEASE SEND BY POST/EMAIL TO:**

**Suite 9, Compass House**

**45 Gildridge Road**

**Eastbourne**

**BN21 4RY**

**Email:** [**info@qualityhealthcareagency.co.uk**](mailto:info@qualityhealthcareagency.co.uk)