NURSE/ ODP APPLICATION FORM

Please fill each box in as required. If you are unable to provide the information, please leave blank.

PERSONAL INFORMATION			
TITLE			
FIRST NAME			
SURNAME			
ADDRESS:			
		CITY:	POSTCODE:
MOBILE:	HOME:	EMAIL:	
DOB:	PASSPORT NO.	NATIONALITY:	

PROFESSIONAL DETAILS		
NMC PIN:	PIN EXPIRY:	REGISTER ENTRY:
JOB TITLE:	QUALIFICATION:	DATE GAINED:

NEXT OF KIN *PLEASE PROVIDE CONTACT DETAILS OF AT LEAST ONE PERSON WE CAN CONTACT IN CASE OF EMERGENCY*			
NAME			
RELATIONSHIP			
ADDRESS			
		CITY:	POSTCODE
HOME:	MOBILE:	EMAIL:	

TRAVEL & WORK PREFERENCES	
Full Driver's Licence? Own Transport	
How Far Are You Willing To Travel?	
Will You Relocate For Work? (With Accommodation)	
Full Time OR Part Time Agency?	
Do You Have A Permanent Post?	
Which Agencies Are Currently Registered With?	
What Shift Pattern Are You Looking For? (Days, Nights, Weekends)	

BANK ACCOUNT DETAILS	
WE PAY YOUR WAGES DIRECTLY INTO A BANK ACCOUNT EITHER DAILY OR WEEKLY	
BANK NAME:	BRANCH NAME:
ADDRESS:	
CITY:	POSTCODE:
ACCOUNT NAME:	LIMITED COMPANY: YES ☐ NO ☐
SORT CODE:	ACCOUNT NUMBER:

EMPLOYMENT HISTORY

- Please supply details of your work history from school to date
- Please explain any gaps of 2 weeks or more
- CV is acceptable as long as full history with month and years
- Please continue of a different sheet if necessary

Date From MM/YY	Date to MM/YY	Name and Address of Employer	Principal Duties	Band/Grade	Reason For Leaving

PLEASE CAN YOU OUTLINE ANY GAPS IN YOUR EMPLOYMENT HISTORY

EDUCATION HISTORY

- Please supply details of your EDUCATION HISTORY
- Please continue of a different sheet if necessary

Date From MM/YY	Date to MM/YY	Name And Address Of Institution	Qualification	Grade

YOUR CLINICAL EXPERIENCE

Please tick up to 3 boxes to indicate areas you have expertise in

A&E		Cardiac		Clinics	
Community		Diagnostic imaging x-ray		Elderly Care	
Endoscopy		General Wards		Gynaecology	
HDU		Health Visitor		Homecare	
ITU		Learning Disabilities		Medical	
Mental Health		Midwifery		Neonatal	
NICU		Nurse Practitioner		Nursing Homes	
Occupational Health		ODP		Oncology	
Chemotherapy		Orthopaedics		Paediatric A&E	
Paediatrics		Palliative		PICU	
Practice Nurse		Prison		Radiology	
Recovery		Renal		Dialysis	
SCBU		Surgical		Theatre	
Triage		Urology		Walk in Centres	
Other Please Specify					

NEW EMPLOYEE CLINICAL MEDICAL QUESTIONNAIRE

CONFIDENTIAL

The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake the duties of the post you have been offered or place you at any risk in the workplace. We may recommend adjustments or assistance as a result of this assessment to enable you to do the job. Our aim is to promote and maintain the health of all people at work. Before health clearance is given for employment you may be contacted by Healthier Business UK Ltd and may need to be seen by an occupational health advisor or physician. Your record will be held on file for a short period of time and may be subject to audit. Your file may also be used to cross reference and ascertain your fitness should you register with other clients of Healthier Business UK Ltd.

Personal Information			
Title	Surname	First names	DOB
Home Tel:	Work Tel:	Mobile:	
Home Address:	GP Address:		

Medical History		
All staff groups complete this section	Yes	No
Do you have any illness/impairment/disability (physical or psychological) which may affect your work?		
Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?		
Are you having, or waiting for treatment (including medication) or investigations at present? If your answer is yes, please provide further details of the condition, treatment and dates		
Do you think you may need any adjustments or assistance to help you to do the job?		

If you have indicated yes to any of the above questions you must provide further details in additional information section, failure to do so will result in the form being returned/rejected.

Additional Information (If you have answered yes to any questions above please provide additional information below)

Tuberculosis		
Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006)	Yes	No
Have you lived continuously in the UK for the last year (Include Holidays/ Vacations)		
If you answered NO to the above, please list all of the countries that you have lived in/visited over the last year, including holidays and vacations. This MUST include duration of stay and dates or this form will be rejected.		
Have you had a BCG vaccination in relation to Tuberculosis?		
If you answered yes please state when	Date	

Tuberculosis Continued		
Do you have any of the following	Yes	No
A cough which has lasted for more than 3 weeks		
Unexplained weight loss		
Unexplained fever		
Have you had tuberculosis (TB) or been in recent contact with open TB		

EVD (Ebola Virus Disease)		
Any person who has been in West Africa in the previous 21 days or those wishing to visit the affected areas must ensure that those deemed the employer are made aware prior to travel and return. You will be provided with a separate Ebola Screening Questionnaire to complete as applicable.	Yes	No
Have you travelled to any countries affected by Ebola? (Guinea, Sierra Leone, Liberia or Mali)		
If you answered YES to the above, please list all of the countries that you have lived in/visited in the last 21 days including holidays and vacations. This MUST include duration of stay and dates or this form will be rejected.		

Additional Information (If you have answered yes to any questions above please provide additional information below)

Chicken Pox or Shingles		
Have you ever had chicken pox or shingles		
Yes	**No**	**Date**

Immunisation History								
Have you had any of the following immunisations						**Yes**	**No**	**Date**
Triple vaccination as a child (Diptheria / Tetanus / Whooping cough)								
Polio								
Tetanus								
Hepatitis B (If Yes is ticked please give dates below)								
Course:	1		2		3			
Boosters:	1		2		3			

Proof of Immunity (Please send the following)	
Varicella	You must provide a written statement to confirm that you have had chicken pox or shingles however we **strongly advise** that you provide serology test result showing varicella immunity
Tuberculosis	We require an occupational health/GP certificate of a positive scar or a record of a positive skin test result **(Do not Self Declare)**
Rubella, Measles & Mumps	Certificate of **"two"** MMR vaccinations or proof of a positive antibody for Rubella and Measles
Hepatitis B	You must provide a copy of the most recent pathology report showing titre levels of 100lu/l or above
Proof of Immunity (Please send the following) EPP Candidates Only	
Hepatitis B Surface Antigen	Evidence of a negative Surface Antigen Test Report must be an identified validated sample. (IVS)
Hepatitis C	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)
HIV	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)

Exposure Prone Procedures		
Will your role involve Exposure Prone Procedures	Yes	No

Declaration		
I will inform my employer if I am planning to or leave the UK for longer than a three month period to enable a reassessment of my health to be conducted on my return. I declare that the answers to the above questions are true and complete to the best of my knowledge and belief. I also give consent for the Healthier Business UK Ltd to make recommendations to my employer.		
Name	**Signature**	**Date**

PROFESSIONAL CONDUCT		
Have there been any proceedings of medical negligence or professional misconduct against you?	Yes	No
If yes please supply details		

REHABILITATION OF OFFENDERS ACT		
Because of the nature of the work for which you are applying, Section 4(2), and further orders made by the Secretary of State under the provision of this section of the Rehabilitation of Offenders Act (1974) (Exceptions) Order 1975 applies. Applicants are therefore required to give information about convictions which for other purposes are "spent" under the provisions of the Act. Any information given will be completely confidential and will be considered only in relation for positions to which the order applies		
Have you at any time been convicted of an offence	Yes	No
If Yes please supply details;		

Signature	Date
Name	

REFERENCE DETAILS
• Please supply the names and work addresses of at least 2 clinical professional referees
• One must be from your present or most recent employer and **must** be a **senior grade** to yourself
• The references **must cover a period of 3 years in total**

CLINICAL REFERENCE 1	
Name	
Position	
Address	
Daytime Phone	Post code
Email Address	
Date	
What was your professional relationship with this person?	
From:	To:

CLINICAL REFERENCE 2	
Name	
Position	
Address	
Daytime Phone	Post code
Email Address	
Date	
What was your professional relationship with this person?	
From:	To:

CLINICAL REFERENCE 3	
Name	
Position	
Address	
Daytime Phone	Post code
Email Address	
Date	
What was your professional relationship with this person?	
From:	To:

DECLARATIONS

1. **Compliance**
   I understand that I am responsible for ensuring that my personal compliance such as my NMC registration, re-validation, DBS update service and NHS mandatory annual training are kept up to date. If any of these lapse I will be unable to work until I am fully compliant again.

   Signed Date

2. **Terms & Conditions**
   I confirm that the information given in this application is true
   I am permitted to work in the UK
   I understand that my registration is subject to at least two satisfactory references covering three years and enhanced disclosure from the Disclosure and Baring service

   Signed Date

3. **Working Time Regulations**
   For the purpose of the Working Time Regulations 1998 (as amended), I consent to work in excess of an average of 48 hours per week. I understand that I may withdraw this consent by giving Your Venture Healthcare not less than three months' notice. I understand that my registration with any company within the Your Venture Healthcare group can be terminated at any time following unsatisfactory work reports or complaints.

   Signed Date

4. **Bank Details**
   I confirm that the bank details on this form are complete and correct and that any incorrect or incomplete details can result in a delay of any payments.

   Signed Date

5. **Data Protection & Permissions**
   I agree that Your Venture Healthcare retains the right to hold this application and any other data required to process it and to pass on to any authorised third party for the purposes of audit and work placements.

   I agree that Your Venture Healthcare can retain these details for as long as reasonably necessary in accordance with the Data Protection Act.

   Signed Date

6. **Disclosure and Barring Update Service Checks**
   I agree that Your Venture Healthcare can access the DBS update service portal to check for any changes to my DBS clearances as and when necessary

   Signed Date

7. **Handbook Declaration**
   I have received (or downloaded) the company handbook and have understood and will comply with it at all times. I am aware that any amendments or new versions will be available on the appropriate company website.

   Signed Date