Please affix
Passport size
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INTRODUCTION

Honesty and integrity of staff is paramount it is important to Cecelia's Nursing Agency and its clients. All candidates are subject to screening, for which this application form will be the basis. It is important that the information you provide is **complete** and **accurate**. Do not use abbreviations, please provide full names, addresses, fax and telephone numbers. If a section or question does not apply to you write "N/A". Do not leave any sections blank. An incomplete form is automatically discredited for the recruitment process. All information is treated as private & confidential.

Section 1- Personal Details

Title: Mr ☐ Miss ☐ Mrs ☐ Ms ☐	Surname	First Name	Maiden Name (if any)
Current Address: Post Code: Email address:			Date of Birth National Insurance Number Religion Home Telephone Number Mobile Number NMC PIN Number Band/ Grade ISA Checked Yes ☐ No ☐
Next of kin (to be notified in case of emergency) Name:			
Address:			
Telephone:		Relationship:	
Do you have a UK driving license? Yes ☐ No ☐			
Do you have access to a car? Yes ☐ No ☐			

Section 2- Nationality and Immigration

Do you hold a UK passport? Yes □ No □

If yes please move to section 3
If no please continue with this section

What is your nationality? _____ What type of passport do you hold? _____

Are you required to have a visa? Yes □ No □ If yes when does it expire? / / 20

If yes please state your type of visa _____

Do you require a work permit? Yes □ No □

Do you have a Home Office Letter to accompany your visa? Yes □ No □ (If yes please give copy.)

Section 3 (a) – Educational History (Please start with your most recent)

Name and address of Institutions	Date		Exams	Subjects
	From	To		

Section 4 (a) Employment History (Please start with your most recent)

Employers Name /Address & Telephone No:	Date		Job Title & Responsibilities	Reason for Leaving (If Applicable)	Other
	From	To			

Section 4 (b) – Employment History Continued

Are you currently still employed with your last employer? Yes □ No □

Will you be bringing a P45 to us? Yes □ No □

When are you available to start? _____

What type of employment are you seeking?

Full Time □ Part Time □ Night □ Day Duty □

Are you available to work at short notice? Yes □ No □

Has disciplinary action been taken against you within the last 6 months? Yes □ No □
If yes give reasons _____

Do you have any commitments that reduce your flexibility to work? Yes □ No □
If yes please state: _____

_____

Section 5 (a) – Specialities/Experience

Which areas of specialities do you have experience in?

Areas	Months/ Years

I declare that all the information I have given in the check list is true and correct to the best of my knowledge.

Name: _____ Signature: _____ Date: _____

Section 7 (a) – Mandatory Training

Please give details & dates of courses attended not included above:

Name of Mandatory Training	Date of last training	Date update required
Moving & Manual Handling		
Fire Safety		
Health & Safety		
Infection Control		
First Aid		
Food Hygiene		
Medication Administration		
Safeguarding Adults (POVA)		
BLS/PLS Resuscitation of newborn (for Midwives)		
CPR		

Section 7 (b)

If your mandatory certificates are up to date are you able to provide us with your certificates? Yes □ No □

If no why not _____

If you are unable to provide us with certificates you will be required to either do our training courses or train elsewhere.

Please state agreement _____

Signature

Section 8 IMMUNISATION REQUIREMENTS

Have you been immunised for the following: If yes please give date of immunisation.

Occupational Health	Yes □ No □	Certificate: Yes □ No □
Hepatitis A	Yes □ No □	Certificate: Yes □ No □
Hepatitis B	Yes □ No □	Certificate: Yes □ No □
Hepatitis C	Yes □ No □	Certificate: Yes □ No □
Rubella	Yes □ No □	Certificate: Yes □ No □
Measles	Yes □ No □	Certificate: Yes □ No □
Mumps	Yes □ No □	Certificate: Yes □ No □
BCG (TB Vaccination)	Yes □ No □	Certificate: Yes □ No □
Varicella (Chicken Pox)	Yes □ No □	Certificate: Yes □ No □
HIV	Yes □ No □	Certificate: Yes □ No □

Please provide evidence of these immunisations.

Section 9 DISABILITY

Do you consider yourself to have a disability? Yes □ No □

If you have answered YES please select the definition/s from the list below that describe your disability/disabilities:

Hearing (such as: deaf, partially deaf or hard of hearing) Yes □ No □

Vision (such as: blind or fractional/partial sight. This does not Include people whose vision can be corrected by glasses/ contact lenses) Yes □ No □

Speech (such as impairment that can cause Communication problem) Yes □ No □

Mobility (such as: wheelchair user, artificial lower limb(s) (Walking aids, rheumatism or arthritis Yes □ No □

Physical co-ordination (such as: manual dexterity, muscular control, cerebral palsy) Yes □ No □

Learning difficulties (such as: dyslexia) Yes □ No □

Mental illness (substantial and lasting more than a year, depression or psychoses),

Reduced physical capacity (such as: inability to lift, carry or otherwise move everyday objects, debilitating pain and lack of strength, breath, energy or stamina, asthma, angina or diabetes) Yes □ No □

Are you allergic to any types of gloves: Powdered □ Latex □ Powder free □

Other allergy – please specify: _____

Other disability please specify _____

ADDITIONAL INFORMATION

The number of days you have been absent from work due sickness, during the last 12 months of employment:

_____

Reasons for these absences: _____

Nature of sickness, if sickness is reason for absence: _____

Do you expect to ask for leave of absence for medical reasons during the next 12 months? Yes □ No □

Name and address of General Practitioner: _____

Telephone number of General Practitioner: _____

Declaration: I declare that the information given above is true to the best of my knowledge.

Signature: _____ Date: _____

Section 9– CRIMINAL RECORDS

Rehabilitation of Offenders Act 1974 and Criminal Records.

By virtue of the Rehabilitation of Offenders Act 1974 (Exemptions) (amendments) order 1986 the provision of section 4.2 of the Rehabilitation of Offenders Act 1974 do not apply to any employment which is concerned with the provision 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. You should therefore list all offences on separate sheet even if you believe them to be "SPENT" or "OUT" of "DATE" for some other reason.

Have you been convicted of a criminal offence YES / NO

Have you ever been cautioned or issued with a formal warning for any Criminal Offence YES / NO
If you have answered "YES" please attach details including dates on a separate sheet.

CRB- The Criminal Records Bureau is the executive agency of the home responsible for conduction checks on criminal records. We are a registered body for receipt of CRB disclosure information. NHS Trust and Private Sector hospitals and nursing homes insist on agencies making information recruitment decisions which require criminal record checks to be made on all staff. It is a condition of proceeding with your application that you apply for CRB disclosure. This disclosure will be compared with the Information given above in Section 7 and any inconsistencies could invalidate your application or lead to the cancellation of your registration with us.

Signed: _____ **Date: _____**

DECLARATION

I have completed the details in the document and declare to the best of my knowledge that the information given is correct. I consent to it being held on file under the terms of the Data Protection Act 1998.

Print Name: _____

Signature: _____ Date: _____

FOR OFFICE USE ONLY

Passport picture received	**Yes** □ **No** □	**Bank details given**	**Yes** □ **No** □
NMC Pin details received	**Yes** □ **No** □	**Staff details form completed**	**Yes** □ **No** □
CRB application made	**Yes** □ **No** □	**POVA application made**	**Yes** □ **No** □
Immunisation certificates seen	**Yes** □ **No** □	**GSCC Registered**	**Yes** □ **No** □
ISA Registered	**Yes** □ **No** □		

Registration Number _____ **Date & Time of Interview _____**

Place Interview Held _____ **Position of Interviewer _____**

Name of Interviewer _____ **Signature of Interviewer _____**

Application Approved □ **Application Withdrawn** □

Section 10– REFERENCES

Please give the names and addresses of 2 professional people of a senior position to you from whom references may be obtained. One of these must be your present and most recent employer.

Reference 1: Current Employer

Name (Mr, Mrs, Ms, other) Surname _____ **First Name** _____

Job Title: _____

Work Address: _____

_____

Post Code: _____

Telephone No: _____ **Fax:** _____

Email Address :_____

How long has this person known you: _____

In what capacity does this person know you: _____

Reference 2: Previous Employer

Name (Mr, Mrs, Ms, other) Surname _____ **First Name** _____

Job Title: _____

Work Address: _____

_____

Post Code: _____

Telephone No: _____ **Fax:** _____

Email Address :_____

How long has this person known you: _____

In what capacity does this person know you: _____

Reference 3: Other Reference

(This section should only be used if you are unable to provide reference 1 & 2.)

Name (Mr, Mrs, Ms, other) Surname _____ **First Name** _____

Job Title: _____

Work Address: _____

_____

Post Code: _____

Telephone No: _____ **Fax:** _____

Email Address :_____

How long has this person known you: _____

In what capacity does this person know you: _____