

APPLICATION FORM



FIELDS MARKED WITH * ARE APPLICABLE FOR NURSES ONLY, PLEASE LEAVE THESE BLANK IF YOU ARE NOT A NURSE.

For Official Use Only

Date Processed		Processed by whom	
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About The Job

Position Applied For	
Date processed	
How did you hear about us (<i>if referred please state the name of the person who referred you</i>)	

About You

Surname		Title (Mr/Mrs/Miss/Ms)	
First Name(s)		Address	
Post Code			
Home Phone		Mobile Phone	
NMC Pin No (if applicable)			
E-mail			
National Insurance Number			
Have you ever been convicted of a crime?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have permission to work in the UK?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Date Of Birth		Nationality	

Your Payment Details

Name of Bank/Building Society			
Account Name		Personal <input type="checkbox"/>	LTD <input type="checkbox"/>
Branch Address & Post Code			
Account No		Sort Code	

Next of kin

Name of Next of Kin		Relationship	
Phone Number			
Contact Address			

Qualifications and Education

(Original documents as proof of qualification will be required at interview)

Secondary School / College / University	Date Attended	Results/Qualification

Other Relevant Training / Qualifications NVQ's

Secondary School / College / University	Date Attended	Results/Qualification

Employment History

Start dates and end dates should be shown in a mm/yy format

The first employment history should be your last or present employer

This must include the last 5years employment history with dates.

Start Date:	End Date:	Employer:
Job Title And Main Responsibilities:		
Start Date:	End Date:	Employer:
Job Title And Main Responsibilities:		
Start Date:	End Date:	Employer:
Job Title And Main Responsibilities:		
Start Date:	End Date:	Employer:
Job Title And Main Responsibilities:		

Start Date:	End Date:	Employer:
Job Title And Main Responsibilities:		

DBS

Are you willing to undergo a full enhanced DBS with this application for work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you willing to pay the required fee of £54.40 for a DBS disclosure check?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

References

Please supply us with two professional referees. One must be from your present or most recent employer and must be a senior grade to yourself and you must have worked for that person for a period of not less than three months duration.

1. Name of employer		Referee Name	
Address			
Post Code			
Your Job Title			
2. Name of employer		Referee Name	
Address			
Post Code			
Your Job Title			

Current notice period _____

I agree for you to contact these references and only once references have been received will my application go any further.

I certify that the information on this form is to the best of my knowledge correct. I understand that any engagement entered will be subject to satisfactory references being received and a satisfactory DBS Disclosure.

Signature _____

Date _____

Skills and Experience Checklist

Community care	Hospitals	Home care	
Nursing Homes	EMI / Dementia Home	Adults with Learning Disability	Adults with Mental Health issues
Children with Mental Health Issues	Autism/ Aspergers Syndrome,	Acquired Brain Injury	Palliative Care
Physical Disability	Supported Tenancy	Respite Centres	Day Care Centres
Children's Homes	Prison Services	Hospices	Sheltered Accommodation
Parkinson's Disease	Diabetes	Epilepsy	Catheter Care
Stoma Care	Administration of Medicines	Challenging Behaviour	Person Centred Planning
Record Keeping	Bath/Shower/Strip wash	Mouth Care	Care Of Feet
Dressing/ Undressing	Bed Bath	Emptying Catheter Bag	Changing Colostomy Bag
Recording Fluid Intake	Moving and Handling Service Users	Use of Walking Aids	Use of Hoists
Current Moving and Handling Course	Preparation of Meals	Feeding Service Users	Pressure Area Care
Experience of Caring for Terminally Ill	Answering Telephones	Taking messages	Bed making
Changing a bed with a service user in it	Light Housework	Experience of Dementia	

Nurses Only *

Male Catheterisation	Female Catheterisation	IV Cannulation	IV Medication
IV Therapy	Defibrillation	Peg feeds	Tracheotomy Care
Patient controlled analgesia	Phlebotomy	O2 Therapy inc Nebulisers	Wound care

Stoma care	Drains	Endoscopy	Use of suction equipment
Bladder washouts	B.M monitoring	Sub- cutaneous fluids	Naso- gastric tubes
Theatres/ Recovery	Neurology	Intensive care units	Coronary care
Chest wards	A & E	Paediatrics	Orthopaedics
Haematology	Oncology	Cardiothoracic	

EQUALITY AND DIVERSITY MONITORING FORM

Convert healthcare is committed to Equal Opportunities in employment and welcome applications from all sections of the community. In order to ensure the effectiveness of this policy and for no other purpose you are requested to place a tick in the appropriate boxes below and complete the details as required. The information is exclusively for monitoring purposes and will be kept strictly confidential.

Surname			
First Name(s)			
Post Code			
Street address		Street address Line 2	
City		State / Province	
Postal / Zip code			
Job Applied For		Date of Birth	
Sex	Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say <input type="checkbox"/>	Status	Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>

Please tick the appropriate box that indicates your cultural background.

A-White		B-Mixed		C- Asian or Asian British		D- Black or Black British		E- Chinese or other ethnic group	
British		White		Indian		Caribbean		Chinese	
Irish		White and black Caribbean		Pakistani		African		Any other , please specify	

Any other white background, Please specify:	White and Black African	Bangladeshi	Any other Black background please specify:		
	Any other mixed background, please specify:	Any other Asian background, please specify:			

Please tick the box that indicates your religious background

None	Buddhist	Muslim	Jewish
Christian	Hindu	Sikh	
Any other religion, Please Secify			

Sexual Orientation

Heterosexual	Gay/ Lesbian	Bisexual	Prefer not to say
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The Disability Discrimination Act 1995 defines a disabled person as anyone who has a physical or mental impairment which has a substantial and long term effect on their ability to carry out normal day to day activities.

Taking this definition into consideration do you have a Disability? Yes No

If YES, then please give details:

How did you find out about the vacancy?

Signature:

Date:

FAILURE TO COMPLETE THIS FORM WILL NOT AFFECT YOUR APPLICATION. If you believe that there has been unfair discrimination in making the appointment, there is a process of investigation available, subject to

reasonable grounds for suspicion being identified. If you wish to pursue an unfair discrimination complaint, please contact the Director of Convert Healthcare.

Your Declarations

1. working time Regulations

I understand that I am under no obligation to work more than an average of 48 hours in any week - these hours include any hours that I work with other employers as well as Convert Healthcare.

I further understand that I may work more than 48 hours per week if I wish.

under the terms of engagement, I realise that I may turn down any assignment at any time, for any reason without detriment.

By signing this declaration, I am signifying that any access of an average of 48 per week are worked by my choice, but also make it clear that this declaration does not mean that I will work more than an average of 48 hours in any week.

I undertake to inform if the total number of hours I work in a week from all forms of employment exceeds 48, in order that Convert Healthcare may take this into consideration before offering work to me.

I understand that it is necessary to inform the agency of my availability for work each week and accept that there is no guaranteed hours of work.

Signed:	Print Name	Date
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2. Identification Authority

In line with the requirements of current legislation I give Convert Health Care my permission to hold and transmit my photograph and date of birth, when necessary, to those clients who require identification cards when on assignment for them.

Signed:	Print Name	Date
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3. Confidentiality Agreement

I confirm that during every assignment and afterwards:

1) To hold information relating to the client in the strictest confidence, ensure it is kept safely and securely when not in use. I acknowledge that no information is to be removed from the client's premises without the permission of the client.

2) To use such information only for the purpose of the week for which it was given.

3) Not to disclose to any third party or copy the information except as it required in the course of my duties.

4) Any breach, either by me or a third party, may result in legal proceedings being brought by the Client against me to recover any losses that have occurred because of a breach.

Signed:	Print Name	Date
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Any conversations that compromise the patient relating to the above statement may jeopardise my position with Convert Healthcare.

4. Audit

I am aware that during the course of my time with Convert Healthcare, my information may be required by an external party for auditing purpose. This includes my personal data and any other data relating to the work in question given to me by Convert Healthcare. I hereby give my consent for Convert Healthcare to share my information and documents for the purposes of an audit for an auditor to check and review should the occasion arise. We would like to inform you that your details and information will be stored at our office for a period of six years. This is in line with GDPR policies.

Signed:	Print Name	Date
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5. Uniform Deduction Form

I accept that I must wear a uniform together with black trousers and black shoes (no high heels or trainers) on any care assignment with Convert Healthcare. Jeans and non - closed shoes are not acceptable.

My Uniform size is:

I am happy to pay a total fee of £20

i understand that I must not wear my uniform when working for anyone other than Convert Healthcare.

I also give permission to Convert Healthcare, to make deductions from my wages for the cost of my uniform.

I understand and agree to the above:

Signed:	Print Name	Date
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6. Working with Challenging Behaviour

When working in this industry there are hazards associated with the industry. I appreciate and accept that one of these hazards is possible aggressive behaviour from challenging service users. Service users may present challenging and aggressive behaviour and this is out of the control of Convert Healthcare.

I understand and accept that I am under no obligation as an agency worker to accept assignments. I accept that there is this risk and accept that this risk is as a result of the industry and not of Convert Healthcare.

I understand that if I am unhappy with an assignment I can withdraw my submission at any time with reasonable notice dictated in my contract for service, and as a result will not hold Convert Healthcare liable for any injury or loss of earnings as an agency worker.

I understand that as an agency worker I am not employed by Convert Healthcare and therefore I am not guaranteed any assignments and have no claim against Convert Healthcare at any time for any reason whatsoever for loss of any earnings as an agency worker.

I understand that if I am injured or affected in any other way whilst on an assignment that this is not the fault or liability of Convert Healthcare.

I understand and agree to the above in its entirety:

Signed:	Print Name	Date
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7. Charges

I also understand that I need to give at least 12 working hours' notice if cancelling a shift or I will be charged a fee of up to £50, we understand there are certain situations that cannot be helped, and we will always take these into consideration. When cancelling a shift, I understand that I should call the office phone numbers as well as texting.

I understand and agree to the above:

Signed:	Print Name	Date
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8. SEVERABILITY

If any of the provisions of these Terms shall be determined by any competent authority to be unenforceable to any extent, such provision shall, to that extent, be severed from the remaining Terms, which shall continue to be valid to the fullest extent permitted by applicable laws.

9. NOTICES

All notices which are required to be given in accordance with these Terms shall be in writing and may be delivered personally or by first class prepaid post to the registered office of the party upon whom the notice is to be served or any other address that the party has notified the other party in writing, by email or facsimile transmission, when that email or facsimile is sent.

10. GOVERNING LAW AND JURISDICTION

These Terms are governed by the law of England & Wales / Scotland and are subject to the exclusive jurisdiction of the Courts of England & Wales.

Signed:	Print Name	Date
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RIGHT TO WORK IN THE UK

Please complete the form, regardless of your nationality, as it is a legal requirement. If you are an overseas national or require a work permit to work in the UK, please include copies of supporting documentation.

Your entitlement for working in the UK is based upon what status

<input type="checkbox"/> UK Citizen	<input type="checkbox"/> Spouse of an EU citizen	<input type="checkbox"/> Work Permit	<input type="checkbox"/> EU Citizen
<input type="checkbox"/> Permit-Free Visa	<input type="checkbox"/> Right of Abode in the UK		

COMPLIANCE POLICY DECLARATION

I have read a copy of the Compliance Maintenance Policy and the Deposit for DBS and Training Policy which outline the steps taking to maintain my compliance yearly. I have familiarized myself with the contents and steps I need to take to make sure my file is up to date, and I am compliant if I am working our organization.

By my signature below, I acknowledge, understand, accept, and agree to comply with the information contained in the Compliance Maintenance Policy provided to me by our organisation.

Signed	Print Name	Date
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AGENCY WORKER HANDBOOK DECLARATION

I have read a copy of the Agency Worker Handbook which outline the goals, policies, benefits and expectations of this Convert Healthcare and its contracting Authorities / Clients as well as my responsibilities as an Agency Worker.

I have familiarized myself with the contents of this handbook. By my signature below, I acknowledge, understand, accept and agree to comply with information contained in the Agency Worker Handbook and the terms of engagement details provided to me by organisation. I understand this handbook is not intended to cover every situation which may arise whilst on assignment, but it is simply a general guide to the goals, policies, practices, benefits and expectations organisation.

I understand that the Agency Worker Handbook is not a contract of employment and should not be deemed a s such

Full Name			
Profession		Registration #	
Signature			
Date			

I hereby give permission for our Convert Healthcare to allow access, as a minimum, to my personnel files as part of any official audit, or client compliance purpose carried out by, but not limited , any person authorised by the NHS. These personnel files will be viewed in accordance with the requirements of the Data Protection Act 2018and General Data Protection Regulations.

Sign		Date	
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GDPR CONSENT

In order to continue to keep you up to date with your payslips and future job opportunities, please respond below verifying you are happy to continue to receive this communication from us. As of the 25th May 2018, we can no longer continue to communicate with you via Email, SMS or Post, unless we receive your permission to do so due to the new GDPR regulations.

Failure to respond will result in us being unable to send you your payslip via email on a weekly basis as well as any communication relating to Convert Healthcare's activity.

I would like to receive communications via: *

Email	<input type="checkbox"/>	<input type="checkbox"/>
Post	<input type="checkbox"/>	<input type="checkbox"/>
Landline	<input type="checkbox"/>	<input type="checkbox"/>
Mobile	<input type="checkbox"/>	<input type="checkbox"/>

Sign		Date	
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Full Name			
Profession		Registration #	
Signature			
Date			

I hereby give permission for our Convert Healthcare to allow access, as a minimum, to my personnel files as part of any official audit, or client compliance purpose carried out by, but not limited, any person authorised by the NHS. These personnel files will be viewed in accordance with the requirements of the Data Protection Act 2018 and General Data Protection Regulations.

Sign		Date	
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PERSONAL DECLARATION

I hereby confirm that the information provided on the applications correct and to the best of my knowledge and that I have not withheld any information that should be taken into account when offering me work.

I understand that providing false or inaccurate information may result in the termination of any placement.

I agree that I will make best endeavours to make myself aware of the health and safety procedures for each client I am assigned to. I confirm that I have read and understood the terms of engagement and the terms of declaration agree to be bound by them.

Sign		Date	
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