Network Healthcare
health and social care

Branch details:	Please attach photograph:

APPLICATION FORM

POSITION APPLIED FOR	
PERSONAL DETAILS	
(Mr / Mrs / Miss / Ms) Surname:	Forenames:
Nationality:	National Insurance Number:
Full Address:	
Postcode:	
Telephone: Number (home):	Mobile Number:
Email:	
Please state your current / last job title within care:	
Do you hold a current full driving licence? ☐ Yes ☐ No	Do you have a car available ☐ Yes ☐ No
NEXT OF KIN (to be notified in case of emergency)	
Full Name (to include Title, Surname and Forenames):	
Full Address:	
	Postcode:
Telephone Number (home):	Relationship:

EDUCATION	
Please provide details of your Secondary Education	
Name of School:	
Date of Attendance from:	to:
QUALIFICATIONS & GRADES	
Please provide details of your Further Education / Training	
Name of Establishment:	
Date of Attendance from:	to:
ADDITIONAL / PROFESSIONAL QUALIFICATIONS	

EMPLOYMENT HISTORY

Please give details of your complete employment history ***(please attach cv)****. Please include reasons for any gaps. Please continue on a separate sheet if necessary.*

Name and Address of Employer	Position	Date from	Date to	Grade	Reasons for leaving

EXPERIENCE QUESTIONNAIRE

To enable us to assess your experience could you please TICK the appropriate boxes

Experience of working in hospitals	☐	Care of feet (excluding toenails)	☐
- please state areas i.e. HDU, Renal, Oncology	☐	Dressing / undressing	☐
-		Bed bath	☐
-		Shaving	☐
-		Care of hair	☐
-		Care of bladder and bowels	☐
-		Use of bedpan / commodes etc	☐
Nursing/Residential homes	☐	Emptying catheter bag	☐
E.M.I Units	☐	Changing colostomy bag	☐
Experience of working in learning disabilities services	☐	Moving and handling patients	☐
Experience of working in mental health services	☐	Use of walking aids	☐
Experience of working in residential childrens homes	☐	Use of hoist	☐
Experience of caring for the terminally ill	☐	Obtaining simple specimens	☐
Experience of working in youth offending services	☐	Preparation of meals	☐
Experience of working in a youth club	☐	Feeding patients	☐
Experience of working with children with learning disabilities	☐	Pressure area care	☐
Experience of caring for those with physical disabilities	☐	Ensuring medication has been taken	☐
Experience of spinal injury care	☐	Observing changes in patients / clients and reporting	☐
Experience of acquired brain injury care	☐	Simple dressings	☐
Experience of stroke patient care	☐	Assisted with Last Offices	☐
Experience of caring for people with degenerative conditions	☐	Assisted with Occupational Therapy including sport & play	☐
Experience of taking and recording general observations	☐	Bed making	☐
- please state which i.e. blood pressure, pulse, fluid balance, temperature		Changing a bed / drawsheet with patient in / on it	☐
-		Light housework, washing of personal laundry	☐
-		Shopping / collection of pensions	☐
-		Experience in milk kitchens/bottle feeding	☐
-		Peg feeding	☐
Clinic or community based practice	☐	Any other, please state:	
Bath / Shower / Strip wash	☐		
Use of bath aids	☐		
Mouth care (inc. denture care)	☐		

EXPERIENCE QUESTIONNAIRE FOR THOSE WORKING IN NURSERY SETTINGS

Tick environments you have worked:

Private nursery	☐	Number and word games	☐
Local authority nursery	☐	Overseeing outdoor play	☐
Hospital nursery	☐	**Organising:**	
Reception class / kindergarten	☐	Organising and leading group activities	☐
Primary school classroom assistant	☐	Planning & setting out themed activity areas	☐
College nursery / crèche	☐	Reading stories to group	☐
After school schemes	☐	**Babies:**	
Special needs nursery	☐	Nappy Changing	☐
Other	☐	Washing and dressing	☐
Daily Activities:		Bottle feeding	☐
Welcoming children and parents	☐	Solids Feeding	☐
Providing snacks	☐	Ensuring safe environment	☐
Toileting	☐	Stimulating and interacting	☐
Wash and tidy	☐	**Record Keeping:**	
End of day/session clearing away	☐	Keeping records	☐
Play:		Completing paperwork for childrens files	☐
Ensuring safe play	☐	**Education and development:**	
Sand and water play	☐	Interacting through play	☐
Creative play	☐	Number and word games	☐
Baking	☐	Reading	☐
Music	☐	Writing	☐
Mime & role-play	☐	Cognitive learning awareness	☐
Any other, please state:			

HEALTH DECLARATION		
Do you or have you ever suffered with:	*Tick as applicable*	*If yes, please give further information*
Are you currently taking any medication tablets, special diets or injections?	☐ Yes ☐ No	
Have you ever had to leave employment for health reasons?	☐ Yes ☐ No	
Do you suffer blackouts, fits or giddiness or have any condition of vision/hearing which may effect your ability to work?	☐ Yes ☐ No	
Neurological, migraines, (including epileptic) symptoms, disorders or diseases?	☐ Yes ☐ No	
Is there any aspect current / recent of your health / medical condition / treatment which, might restrict or effect your ability or performance at work.	☐ Yes ☐ No	
Do you or have you suffered cardiovascular symptoms, chest pains, irregular blood pressure, varicose veins, haematological disorders or diseases, asthma, bronchitis or tuberculosis?	☐ Yes ☐ No	Please state
Do you or have you suffered from stress, depression, mental illness or nervous breakdown, alcoholism or drug related symptoms?	☐ Yes ☐ No	If yes we may require additional information from your GP
Have you suffered from gastrointestinal, bowel, typhoid, paratyphoid or dysentery problems?	☐ Yes ☐ No	
Have you any reason to believe you have been infected by any communicable disease?	☐ Yes ☐ No	
Do you suffer Immuno-deficiency symptoms e.g. (HIV positive) disease or disorder?	☐ Yes ☐ No	
Bladder or kidney trouble?	☐ Yes ☐ No	
Dermatitis of skin condition, including allergy to latex gloves or powder?	☐ Yes ☐ No	
Have you ever had mumps, measles, shingles?	☐ Yes ☐ No	
Back problems or rheumatism or arthritis?	☐ Yes ☐ No	
Diabetes, thyroid or other gland problems?	☐ Yes ☐ No	
Are you pregnant?	☐ Yes ☐ No	If circumstances change we must be informed **immediately**
Do you suffer from recurrent sore throats or have you ever been treated for MRSA infections?	☐ Yes ☐ No	
Any accident or illness or any other medical condition that prevented you from attending work or your normal duties or activities for more than 1 month during the past year?	☐ Yes ☐ No	Please state
Do you have any allergies?	☐ Yes ☐ No	
Do you smoke?	☐ Yes ☐ No	How many?
Do you consume alcohol?	☐ Yes ☐ No	How many units per week?
Are you allergic to any Food, Drink, Chemicals or anything else?	☐ Yes ☐ No	Please state:
Have you been abroad in the past two years? If so, please complete and fill in the details below	☐ Yes ☐ No	
Medical Screening Have you got any history of any medical screening? Date of most recent screening and name of hospital / trust	☐ Yes ☐ No	Were the results in anyway abnormal? If so provide details in space below:
If your health changes in any way, please inform Network Healthcare immediately. Failure to do so may invalidate your insurance.		

RECORD OF IMMUNISATIONS

(LAB REPORT FROM AN OCCUPATIONAL HEALTH DEPARTMENT OR G.P. PATHOLOGY REPORT CONFIRMING YOUR IMMUNISATION STATUS, IF REQUIRED)

TYPES OF IMMUNISATION	YES	NO	DATES/RESULTS
Rubella (German Measles)			
Measles Disclaimer:- I have / have not had measles.			Signed: Date:
Hepatitis B (including Titre levels)			
Antibodies			
Tuberculosis BCG / Scar			
Hepatitis C – antibodies			
Immuno-deficiency disorders (Inc HIV)			
Varicella - (Chicken Pox / Shingles). *Disclaimer:- I can confirm that I have suffered from this disease.*			Signed: Date:
Tetanus			
Poliomylitis			

I take full responsibility for entering into employment with Network Healthcare before completing my full course of inoculations against Hepatitis B. I have been advised and am aware that the inoculations have to be completed, however, the position does not depend on this.

Signed:	Date:
Do you agree to being health screened or to obtaining a certificate of fitness from your G.P. or an Occupational Health Service if required?	☐ Yes ☐ No

Have you been abroad in the last two years? If so, please complete the details below:

Country Visited:	Date & Duration of stay	Inoculation required

Name of G.P.	
Address:	
Tel No.	Signed:

FOR NIGHT SHIFT WORKERS ONLY

Have you worked night shifts in the past?	☐ Yes ☐ No
How long have you been working night shifts?	
Have you ever suffered health problems directly related to working night shifts?	☐ Yes ☐ No
If yes, please give details:	
When on night duty, I am able to sleep in the day and incur no health problems	☐ Yes ☐ No

TRAINING

Please provide the dates that you last undertook the following training courses and provide copies of certificates at interview.

Training Course	**Date of Last Training**	**Training Course**	**Date of Last Training**
Moving & Handling		Administration of medication	
Fire safety		Adult abuse awareness (POVA)	
Health & Safety (1974/1999 Acts Including COSSH/RIDDOR)		Food hygiene	
Infection control		Physical Intervention and De-escalation	
B.L.S. / C.P.R.		Interpretation of cardiotocograph traces	
Resuscitation of the newborn		First aid	

Please give details of any further training, for which, certificates must be provided at interview.

WORK PREFERENCE

☐ Full Time ☐ Part Time ☐ Weekends ☐ Weekdays ☐ Nights ☐ Occasional Weeks

Date available to commence:

Please state the geographical locations in which you would like to work:

GENERAL INFORMATION

Do you speak any other language as well as English? ☐ Yes ☐ No

Language	Written			Spoken		
	Fluent	Good	Fair	Fluent	Good	Fair
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

BANK DETAILS

If your account details are not provided, no payment of wages can be made.

Account Details

Name of Bank/Building Society:

Address:

Sort Code: | Account Number:

Account in the name of:

Declaration: I hereby request and authorise Network Healthcare to credit all amounts due to me to my account, detailed above.

Signed: | Dated:

REFERENCES

Please give the names of two professional people, of a senior grade / position to you, including your present or most recent employer, whom we may approach for a reference (not relatives or friends). They must be able to provide a credible comment on your ability to undertake the duties of the post applied for. If the references do not cover the last five years of work, please supply additional referee details on a separate sheet. HOME ADDRESSES OF REFEREES ARE NOT ACCEPTABLE

REFERENCE 1

Name: | Position:

Name of Establishment / Home:

Work Address (not home):

Post Code: | Telephone Number: | Fax Number:

How long has this person known you in a professional/work context?

Was this person senior to you? ☐ Yes ☐ No

REFERENCE 2

Name: | Position:

Name of Establishment / Home:

Work Address (not home):

Post Code: | Telephone Number: | Fax Number:

How long has this person known you in a professional/work context?

Was this person senior to you? ☐ Yes ☐ No

REFERENCE 3

Name:		Position:
Name of Establishment / Home:		
Work Address (not home):		
Post Code:	Telephone Number:	Fax Number:
How long has this person known you in a professional/work context?		
Was this person senior to you? ☐ Yes ☐ No		

REHABILITATION OF OFFENDERS ACT 1974 & CRIMINAL RECORDS

By virtue of the Rehabilitation of Offenders Act 1974 (Exemptions) (Amendments) Order 1986, the provisions 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 a separate sheet even if you believe them to be "spent" or "out of date" for some other reason.

Have you ever 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 answered "yes" please attach details including dates on a separate sheet)	

DBS / Disclosure and Barring Service, is the executive agency of the Home Office responsible for conducting checks on criminal records. We are a registered body for receipt of DBS disclosure information. Clients within the healthcare sector insist on agencies making informed 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 a DBS disclosure. The disclosure will be compared with the information given above in Section 7 and any inconsistencies could invalidate your application.

Name:	Date:

ELIGIBILITY TO WORK

People with an automatic right to work are citizens of the U.K., European Union and E.E.A. and certain Commonwealth citizens.

Do you require a work permit or other permission to take employment in the U.K. ☐ Yes ☐ No		If Yes please provide details below:
Are you visiting Britain on a working holiday? ☐ Yes ☐ No		Do you hold a Student Visa? ☐ Yes ☐ No
Do you require a work permit? ☐ Yes ☐ No		
Passport Nationality:		Place of issue:
Passport Number:	Date of issue:	Expiry date:

WORKING TIME DIRECTIVES

The European Union has laid down guidelines for all workers, governing the length of the maximum working week that it is safe to work. The current limit is 48 hours per week. As you are under no obligation to accept work offered, you will never be compelled to work more than 48 hours per week but you may choose to do so.

Please would you sign below to confirm that you have read and understood this information and please indicate your preferences by **ticking the most appropriate box.**

I DO NOT wish to work more than 48 hours per week	☐
I DO wish to work more than 48 hours per week	☐

Signed:	Date:

ABUSE POLICY

I understand that I must be aware of the prevention of abuse policies that are enforced by the governing council in any placement that I may work in. I have been advised that Network Healthcare will retain a copy of these policies and I can access them at any time.

Signed:	Date:

DATA PROTECTION ACT 1998 & INSPECTION

We are required to hold personal information on staff e.g. National Insurance number, address, qualifications. From time to time we may be required to release elements of this information when placing you in assignments; please be assured that we would only disclose information that is necessary.

We would therefore be grateful if you would complete and sign the declaration below. If you have any concerns about this or want to discuss it further, please contact your branch manager.

I consent/do not consent (circle as appropriate) to the disclosure of information required to place me on assignments.

Print Name:	
Signed:	Dated:

Note: Regulatory bodies such as Social Services, Home Office, Immigration, Care Standards Commission have the right to access personal files for inspection purposes in order to verify compliance with legislation and CQC regulations.

DECLARATION – INVESTIGATION / SUSPENSION

Are you currently suspended from duty with any other organisation? ☐ *Yes* ☐ *No*

Have you ever been investigated or suspended for a disciplinary or other matter, eg for a referral under the POVA / POCA arrangements ? ☐ *Yes* ☐ *No*

If 'YES', please provide details and the current investigation status on a separate sheet.

I agree to inform Network Healthcare Limited if, at any time, whilst registered with them, I am suspended from duty by any other organisation.

Signed:	Dated:

HOME OFFICE IMMIGRATION SERVICE CHECK

I give permission for Network Healthcare to contact the Home Office / United Kingdom Immigration Service in order to establish my immigration status and eligibility to work.

Signed:	Dated:
Do you have indemnity insurance? ☐ Yes ☐ No	Date of expiry:

DECLARATION

The information I have given in this registration form is, to the best of my knowledge, complete and accurate in all aspects. I understand that knowingly giving false information will disqualify me from registration with this agency. I also agree to keep Network Healthcare Limited advised of any changes to any of the information supplied.

Signed:	Dated:
Print Name:	Qualification:

FOR OFFICE USE ONLY

Date Received:

Date Fully Registered:

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