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| **Application Form** | | | | | | | | | | | | | |
| Registered  Nurse  **HCA**  Support Worker | | | | | | | Specialty: | | | | PAYE | |  |
| Umbrella | |  |
| Title: | | First Name: | | | | | Middle Name(s): | | | | | | |
| Surname: | | | | | | | Maiden Names:  (Previous Surname) | | | | | | |
| Marital Status: Single | | |  | | Married | |  | Divorced | |  | Widowed |  | |
| Address: | | | | | | | | | | | | | |
| Town: | | | | | | | Postcode: | | | | | | |
| Email Address: | | | | | | | | | | | | | |
| Phone (Mobile) | | | | | | | Phone (Home): | | | | | | |
| Date of Birth: | | | | | | | National Insurance Number: | | | | | | |
| **Ambrella** | | | | | | | | | | | | | |
| Ambrella Company Name | | | | | | | Contact Details | | | | | | |
| **ALL-Right to Work (Asylum & Immigration Act 1980)** | | | | | | | | | | | | | |
| Are you free to remain and take up employment in the UK? | | | | Yes | | No | Nationality: | | | | | | |
| Passport  Number: | | | | Passport  Issue Date: | | | | | Passport  Expiry Date: | | | | |
| Visa  Type: | | | | Visa  Number: | | | | | Visa  Expiry Date: | | | | |
| EU ID:  (Yes/No) | | | | EU ID  Number: | | | | | EU ID  Expiry Date: | | | | |
| ALL-Next of Kin/Emergency Contact Details | | | | | | | | | | | | | |
| Title: | Name: | | | | | | Surname: | | | | | | |
| Relationship to You: | | | | | | | Address: | | | | | | |
| Town: | | | | | | | Postcode: | | | | | | |
| Phone (Mobile) | | | | | | | Phone (Home): | | | | | | |
| **ALL-Bank/Building Society Details** | | | | | | | | | | | | | |
| Account Holders Name: | | | | | | | Bank Name: | | | | | | |
| Account Number: | | | | | | | Sort Code: | | | | | | |
| I authorise Care24 Recruitment to pay my weekly earnings directly into the bank or building society whose details I have given above. I confirm that I will notify Care24 Recruitment in writing of any changes of these details.  Signature: Date: | | | | | | | | | | | | | |

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| Employment History  Please give details of your employment over the last 3 years commencing with your most recent job and including any agencies worked for. Where applicable, please explain any breaks in employment history. | | | | |
| Date From  (MM/YY) | Date To  (MM/YY) | Name & Address of Employer | Position Held | Reason for Leaving |
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| **All-Education/Qualifications** | | | | |
| Date From  (MM/YY) | Date To  (MM/YY) | Course | Name & Address of University/College/Institute | Qualifications Gained |
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| **All-Your Availability for Work** | | | | | | | |
| How many hours each week would you like to work? | | | |  | | | |
| Which areas would you be able to work in?  (Please list) | | | |  | | | |
| Please indicate the times and days you would be available for work. | | | | | | | |
|  | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Early Shift |  |  |  |  |  |  |  |
| Late Shift |  |  |  |  |  |  |  |
| Long Day |  |  |  |  |  |  |  |
| Night Shift |  |  |  |  |  |  |  |
| Are you a car driver? | | Yes | No | Do you own a car? | | Yes | No |
| Do you have current UK Driving License? | | Yes | No | License Number (if applicable) | | | |
| Issue Date: | | | | Expiry Date: | | | |
| Details of any endorsements: | | | | | | | |
| If you intend to use your car for business, do you have the required insurance cover? | | | | Yes | | No | |
| If yes, you will be required to produce both your driving license and motor insurance certificates. | | | | | | | |
| Do you have any other work commitments which may impair your ability to carry out your duties for CN-Care? | | | | Yes (please give details) | | No | |

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| **All-Equal Opportunities Monitoring** | | | | | | | | | |
| Languages Spoken: |  | | | | | | | | |
| Religion: |  | | | | | | | | |
| Age Group  (Please indicate) | 16-20 | | 21-35 | | 36-50 | | | 50+ | |
| Disabilities  (Please indicate) | Registered Disability | | | Unregistered Disability | | | No Disability | | |
| Ethnicity (please indicate which best describes your ethnic origin) | White European | | | White Other | | | Black African | | |
| Black Caribbean | | | Black Other | | | Indian | | |
| Asian | | | Other (please be specific) | | | | | |
| How did you hear about this post? |  | | |  | | |  | | |
| Are you related to, or do you know any member of staff at CN-Care? |  | | |  | | |  | | |
| Signature: Date: | | | | | | | | | |
| **ALL-Further Training / Mandatory Training** | | | | | | | | |  |
| Course | | Yes/No | | | | Date Attended | | |  |
| Equality and Diversity | |  | | | |  | | |  |
| Health and Safety | |  | | | |  | | |  |
| Fire Safety | |  | | | |  | | |  |
| Infection Control | |  | | | |  | | |  |
| Food Hygiene | |  | | | |  | | |  |
| Manual Handling | |  | | | |  | | |  |
| Basic Life Support | |  | | | |  | | |  |
| Safeguarding Vulnerable Adults | |  | | | |  | | |  |
| Safeguarding Children | |  | | | |  | | |  |
| Conflict Management | |  | | | |  | | |  |
| Complaints Handling | |  | | | |  | | |  |
| Lone Worker | |  | | | |  | | |  |
| Mental Capacity Act | |  | | | |  | | |  |
| Record keeping | |  | | | |  | | |  |
| Information Governance | |  | | | |  | | |  |
| Understanding Your Role | |  | | | |  | | |  |
| Duty of Care | |  | | | |  | | |  |
| Medication Awareness | |  | | | |  | | |  |
| Emergency First Aid | |  | | | |  | | |  |
| Communication | |  | | | |  | | |  |
| COSHH | |  | | | |  | | |  |
| PMVA/MAPA/Control & Restraint | |  | | | |  | | |  |
| Peg feed/ Gastronomy Tubes | |  | | | |  | | |  |
| Tracheostomy | |  | | | |  | | |  |

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| **NURSES-Clinical details** | | | | | | | |
| Clinical Area | Length of experience | Clinical Area | Length of experience | Clinical Area | Length of Experience | Clinical Area | Length of Experience |
| A&E |  | Nursing Homes |  | Family Planning |  | Psychiatric |  |
| Ante Natal |  | Occupational Health |  | GU Medicine |  | Radiology |  |
| Aesthetic Trained |  | ODP |  | Gynaecology |  | Recovery |  |
| Cardiac |  | Oncology |  | Haematology |  | Renal |  |
| Cardiothoracic |  | Ophthalmology |  | Health Visiting |  | Residential Homes |  |
| Care of the older Person |  | Orthopaedics |  | High Dependency |  | SCBU |  |
| Community Nursing |  | Outpatients Department |  | Home Care |  | Screening |  |
| Cosmetic Surgery |  | Paediatrics |  | Hospices |  | School Nurse |  |
| Day Care Unit |  | Phlebotomy |  | In Charge Duties |  | Scrub Nurse |  |
| Day Care Centre |  | Practice Nurse |  | Hospitals |  | Stoma Care |  |
| District Nursing |  | Prisons |  | Intensive care Unit |  | Surgical |  |
| Medical Assessment |  | Urology |  | Learning Disability |  | Terminal Clinic |  |
| Mental Health |  | Vena Puncture |  | Learning Disability |  | Theatres |  |
| Midwifery |  | X-ray |  | Medical |  | Tropical Disease |  |
| Neonatal/PICU |  | Neurology |  | Other: | | | |

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| NURSES-Nursing Skills Checklist  Please tick the box that most applies to your current experience. Please remember that you will be held professionally accountable for all information provided. | | | |
| Administrative Abilities | Novice | Competent | Expert |
| Dealing with confidentiality |  |  |  |
| Report writing |  |  |  |
| Recording instruction from MDT |  |  |  |
| Observing / recording changes in clients’ condition |  |  |  |
| Intravenous Therapy |  |  |  |
| IV Rate calculations |  |  |  |
| Administration of drugs by continuous infusion |  |  |  |
| Administration of drugs intermittent infusion |  |  |  |
| Administration of drugs by direct injection e.g. bolus or push |  |  |  |
| Heparinisation of IV Cannula |  |  |  |
| Administration of blood and blood products e.g. plasma |  |  |  |
| Infusion pumps |  |  |  |
| Syringe drivers |  |  |  |
| Central venous catheter |  |  |  |
| Central venous pressure readings (CVP) |  |  |  |
| Venepuncture (taking blood) |  |  |  |
| Arterial lines: setting up for |  |  |  |
| Taking blood sample |  |  |  |
| Removal |  |  |  |
| Neurological |  |  |  |
| Neurological observations and assessment |  |  |  |
| Care of a patient during and following a seizure |  |  |  |
| Care of a patient with a head injury |  |  |  |
| Care of a patient following a CVA |  |  |  |
| With a spinal cord injury (e.g. quadriplegic/paraplegic) |  |  |  |
| Following spinal injury (e.g. laminectomy) |  |  |  |
| An unconscious patient |  |  |  |
| During and after a lumber puncture |  |  |  |
| Total Parental Nutrition |  |  |  |
| (TPA Hyperalimentation) |  |  |  |
| Knowledge of solutions |  |  |  |
| Care of line |  |  |  |
| Dressing change |  |  |  |
| Gastrointestinal |  |  |  |
| Naso-gastric tube insertion |  |  |  |
| Care of naso-gastro tube |  |  |  |
| Feeding via naso-gastro tube |  |  |  |
| Administration of medicines |  |  |  |
| Care of the patient with abdominal wounds/ drains e.g. gastronomy, PEG |  |  |  |
| Care of the patient undergoing abdominal paracentesis |  |  |  |
| Care of the patient during and after a liver biopsy |  |  |  |
| Care of the patient post abdominal surgery |  |  |  |
| Administration of enemas |  |  |  |
| Administration of suppositories |  |  |  |
| Rectal lavage |  |  |  |

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| --- | --- | --- | --- |
| Renal | Novice | Competent | Expert |
| Insertion of catheter: Male (with certificate) |  |  |  |
| Female |  |  |  |
| Catheter care |  |  |  |
| Suprapubic catheter |  |  |  |
| Nephrostomy tube |  |  |  |
| Bladder lavage and irrigation |  |  |  |
| Care of patient with renal transplant: on haemodialysis |  |  |  |
| On peritoneal dialysis |  |  |  |
| Following nephrectomy |  |  |  |
| Orthopaedics |  |  |  |
| Care of a patient: in plaster of pairs |  |  |  |
| With skin traction |  |  |  |
| With skeletal traction |  |  |  |
| Following amputation |  |  |  |
| Halo traction |  |  |  |
| Crutchfield tongs |  |  |  |
| Stryker frame |  |  |  |
| Spinal lifts |  |  |  |
| Leg rolls |  |  |  |
| Wound Care |  |  |  |
| Changing wound dressing |  |  |  |
| Aseptic technique |  |  |  |
| Removal of sutures: clips |  |  |  |
| Staples |  |  |  |
| Drain dressing (e.g. keyhole-redivac and closed drainage system) |  |  |  |
| Change of vacuum bottle |  |  |  |
| Shortening of a drain (e.g. Penrose, Corrugated) |  |  |  |
| Removal of drain |  |  |  |
| Prevention of drain |  |  |  |
| Prevention of pressure sores |  |  |  |
| Respiratory |  |  |  |
| Oxygen therapy: Nasal Cannula |  |  |  |
| Face mask |  |  |  |
| Suctioning: oropharyngeal |  |  |  |
| Endotracheal |  |  |  |
| Tracheostomy care: changing a dressing |  |  |  |
| Suctioning a tracheostomy |  |  |  |
| Changing a tracheotomy tube |  |  |  |
| Management of chest tubes (under water seal drainage) |  |  |  |
| Changing drainage tubing and bottles (under water seal) |  |  |  |
| Removal of drainage tubes |  |  |  |
| Care of ventilated patient |  |  |  |
| Obtaining arterial blood gases |  |  |  |
| Interpreting arterial blood gases |  |  |  |
| Assisting with intubation |  |  |  |

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| --- | --- | --- | --- |
| Renal | Novice | Competent | Expert |
| Insertion of catheter: Male (with certificate) |  |  |  |
| Female |  |  |  |
| Catheter care |  |  |  |
| Suprapubic catheter |  |  |  |
| Nephrostomy tube |  |  |  |
| Bladder lavage and irrigation |  |  |  |
| Care of patient with renal transplant: on haemodialysis |  |  |  |
| On peritoneal dialysis |  |  |  |
| Following nephrectomy |  |  |  |
| Orthopaedics |  |  |  |
| Care of a patient: in plaster of pairs |  |  |  |
| With skin traction |  |  |  |
| With skeletal traction |  |  |  |
| Following amputation |  |  |  |
| Halo traction |  |  |  |
| Crutchfield tongs |  |  |  |
| Stryker frame |  |  |  |
| Spinal lifts |  |  |  |
| Leg rolls |  |  |  |
| Wound Care |  |  |  |
| Changing wound dressing |  |  |  |
| Aseptic technique |  |  |  |
| Removal of sutures: clips |  |  |  |
| Staples |  |  |  |
| Drain dressing (e.g. keyhole-redivac and closed drainage system) |  |  |  |
| Change of vacuum bottle |  |  |  |
| Shortening of a drain (e.g. Penrose, Corrugated) |  |  |  |
| Removal of drain |  |  |  |
| Prevention of drain |  |  |  |
| Prevention of pressure sores |  |  |  |
| Respiratory |  |  |  |
| Oxygen therapy: Nasal Cannula |  |  |  |
| Face mask |  |  |  |
| Suctioning: oropharyngeal |  |  |  |
| Endotracheal |  |  |  |
| Tracheostomy care: changing a dressing |  |  |  |
| Suctioning a tracheostomy |  |  |  |
| Changing a tracheotomy tube |  |  |  |
| Management of chest tubes (under water seal drainage) |  |  |  |
| Changing drainage tubing and bottles (under water seal) |  |  |  |
| Removal of drainage tubes |  |  |  |
| Care of ventilated patient |  |  |  |
| Obtaining arterial blood gases |  |  |  |
| Interpreting arterial blood gases |  |  |  |
| Assisting with intubation |  |  |  |

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| Cardiovascular | Novice | Competent | Expert |
| Perform 12 lead electro grams (ECG) |  |  |  |
| Cardiac monitoring |  |  |  |
| Telemetry |  |  |  |
| Interpretation of basic arrhythmias |  |  |  |
| Cardiopulmonary resuscitation |  |  |  |
| Defibrillation |  |  |  |
| Assisting with insertion of pacemaker |  |  |  |
| Aortic balloon pump |  |  |  |
| Swans-Ganz catheter |  |  |  |
| Care of patient with acute myocardial infarction |  |  |  |
| Care of patient with congestive cardiac failure |  |  |  |
| Care of post cardiac surgery (e.g. coronary vein grafts, aortic valve) |  |  |  |
| Care of patient post cardiac catheterisation |  |  |  |
| Cardiac |  |  |  |
| Knowledge of drugs used |  |  |  |
| Use of airway and ambu bag |  |  |  |
| Cardiac compressions |  |  |  |
| Other |  |  |  |
| Barrier nursing – infectious/immunosuppresses or MRSA patient |  |  |  |
| Care of patient with eye problems |  |  |  |
| Care of a confused patient |  |  |  |
| Knowledge of the NMC Code of Professional Conduct |  |  |  |
| Knowledge of NMC guidelines for the administration of medicine |  |  |  |

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| Comments/ Any Other Skills |
|  |
| **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Statement of Competence** |
| I *(insert name)* consider myself to be both mentally and physically fit to carry out any duties to work with vulnerable adults or children. + |
| **Print Name:** |
| **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **ALL-Professional References**  Please provide at least two referees who would give reference on your character, work experience and suitability for the post applied for. Referees must be in a senior position to yourself. Please be aware that we are unable to offer you work until satisfactory references have been obtained. Please also note that we are required to obtain references for you on annual basis. | | | |
| **Verified By:** | | **Verified By:** | |
| Name: |  | Name: |  |
| Position held by Referee: |  | Position held by Referee: |  |
| Company’s Name: |  | Company’s Name: |  |
| Company’s Address: |  | Company’s Address: |  |
| Work Telephone: |  | Work Telephone: |  |
| Work Email: |  | Work Email: |  |
| **Verified By:** | | **Verified By:** | |
| Position held by Referee: |  | Position held by Referee: |  |
| Company’s Name: |  | Company’s Name: |  |
| Company’s Address: |  | Company’s Address: |  |
| Work Telephone: |  | Work Telephone: |  |
| Work Email: |  | Work Email: |  |
| I hereby give Care24 Recruitment permission to approach my referees at this stage for employment references and understand that Care24 Recruitment reserve the right to withdraw my application if my references do not meet a satisfactory level of healthcare staffing.  Yes No | | | |

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| **ALL-Addresses from Past 5 Years**  (start with current address) | | | |
| Date From: | Date To: | | Address: |
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| **NURSES ONLY-NMC Registration Checks** | | | |
| Do you authorise Care24 Recruitment to carry out monthly NMC pin checks in order to ensure you remain fit to work?  Yes/ No  \*The role of the NMC is to protect the public by ensuring that nurses, midwives and specialist community public health nurses provide high standards of care. The NMC sets and improves standards for the education, training and conduct of those on the register, and it provides advice and considers allegations of misconduct, lack of competence or unfitness to practice due to ill health. The Fitness to work monthly check purpose is to safeguard the health and wellbeing of the public by assessing if a nurse or midwife’s fitness to work is impaired.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| NMC Pin Number: | | Expiration Date: | |
| Registration Type: (e.g. RGN, RMN etc.) | | | |

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| **All-Convictions/ Disqualifications** | | |
| In view of the nature of the work for which you are applying, the post is considered to be exempt from the previsions of the rehabilitation of offenders Act 1974 as contained within the exceptions Amendment order 1986. Applicants are required to give details of all convictions for criminal offences, including pending convictions and those which would otherwise be considered “spent”. Failure to provide details of convictions could result in dismissal or disciplinary action. If there are no convictions, please state “none”.  Having a criminal record will not necessarily bar you from working with us. Care24 Recruitment complies fully with the DBS Code of Practice regarding the correct handling, use, storage retention and disposal of Disclosures and Disclosure information. We make every subject of a DBS Check aware of the existence of the DBS Code of Practice and make a copy available on request.  Please list any pending investigations below: | | |
| Date: | Offence: | Outcome: |
|  |  |  |
| I confirm that to the best of my knowledge, the details contained above are correct.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **All-Disclosure and Barring Service (DBS) Check** | | |
| I authorise Care24 Recruitment to carry out a DBS check on my behalf and when required. I understand that before I can commence work with Care24 Recruitment, I need to have completed a DBS check.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you have a DBS certificate dated within the last 6 months and registered with DBS?  Yes/No  If yes, please give disclosure number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Valid From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| **ALL -Declaration of Health by Applicant** | |
| Name: | Date of Birth: |
| Home Address: | |
| Phone (Mobile): | Phone (Home): |
| General Practitioner’s Name: | |
| General Practitioner’s Address: | |
| Occupational health Department:  (Your GP will not be contacted without your permission) | |
| Applicants should read the following carefully:  This questionnaire should be completed by you as fully as possible, all questions must be answered. If you run out of space please use a follow up sheet. All information will be treated as medically confident.  **WARNING:** in completing the questionnaire, you are responsible for the accuracy of your statements. If information is withheld, suppressed, deliberately misleading or false, you may be liable, if employment to dismissal.  **NOTE:** A disability or health problem will not in itself preclude full consideration for the job applied for, and applications from people with disabilities are welcome.  The following questions on health and disability are asked in order to find out your needs in terms of reasonable adjustments to access out recruitment service and to find out your needs in order to perform the job or position sought.  Do you have any health issues or a disability relevant which may make it difficult for you to carry out functions which are essential for the role you seek?  ☐A. I am not aware that I have health condition or disability that might impair my ability to undertake effectively the duties of the position that I have been offered.  ☐B. I do have a health condition or disability that might affect my work and may require special adjustments to my work or place of work.  If B. ticked, please specify:  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **All Health Checklist**  **Have you ever had in your life, including childhood, any of the following?** | | | |
| Description of Illness | Yes | No | Details/Date |
| 1. Heart/Circulation Illness/Hypertension? |  |  |  |
| 1. Blood Disorders e.g. Anaemia, Haemophilia? |  |  |  |
| 1. Eye Disease/Injury or Detect of eyesight? |  |  |  |
| 1. Asthma, Hay Fewer? |  |  |  |
| 1. Bronchitis, Pneumonia, Pleurisy? |  |  |  |
| 1. Tuberculosis? |  |  |  |
| 1. Diabetes and/or Frequent Fainting Attacks? |  |  |  |
| 1. Epilepsy? |  |  |  |
| 1. Headaches/Migraine? |  |  |  |
| 1. Psychiatric Treatment? |  |  |  |
| 1. Dermatitis, Psoriasis, Eczema, Skin Sensitivities? |  |  |  |
| 1. Chicken Pox? (if you suffered from it in childhood please tick Yes) |  |  |  |
| 1. Hearing Loss, Frequency Ear Infections? |  |  |  |
| 1. Hepatitis/Jaundice? |  |  |  |
| 1. Bladder/Kidney Infection? |  |  |  |
| 1. Gynaecological Problems, Painful periods? |  |  |  |
| 1. Gastric Ailments, Ulcer? |  |  |  |
| 1. Back Problems/ Sciatica or deformities of spine? |  |  |  |
| 1. Varicose veins? |  |  |  |
| 1. Do you have any deformities, which affects your employment? |  |  |  |
| 1. Are you currently receiving any medication from the doctor? |  |  |  |
| 1. Have you ever been treated at the hospital? |  |  |  |
| 1. Physical or other disability? |  |  |  |
| 1. Psychiatric or mental illness? |  |  |  |
| 1. Are you registered as disabled? |  |  |  |
| 1. Date and result of last X-ray? |  |  |  |
| 1. Allergies? |  |  |  |
| 1. Fractures, tendon, ligament/Cartilage damage? |  |  |  |
| Have you ever been vaccinated, Immunised or tested for/against any of the following? | | | |
| 1. Tuberculosis, including BCG |  |  |  |
| 1. Heaf, Mantoux or Time |  |  |  |
| 1. Rubella (German Measles) |  |  |  |
| 1. Mumps |  |  |  |
| 1. Measles |  |  |  |
| 1. Poliomyelitis |  |  |  |
| 1. Hepatitis B (antibodies date and result) |  |  |  |
| 1. HIV |  |  |  |
| 1. Tetanus |  |  |  |
| 1. Varicella |  |  |  |
| 1. Typhoid |  |  |  |
| Have you ever had any disorders from or received treatment for any of the following? | | | |
| AIDS/ HIV INFECTED HEALTH CARE WORKERS |  |  |  |
| I confirm that I am aware of and have read the department of health’s guidelines on AIDS/HIV infected health care workers issued April 1993 and the GMC’s booklet Serious Communicable Diseases – October 1997 and agree to abide by these guidelines.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

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| **MRSA** | | **Yes/No** |
| Have you had contact with MRSA? | |  |
| If yes, date of swab: | | |
| **Miscellaneous** | | |
| How many days have you been away from work or unable to follow your normal activities because of illness of injury in the last 2 years?  Please give reasons for and the length of each period of incapacity that exceeds three working days: | | |
| Have you ever had to resign from any previous job for medical reasons?  (If yes, please explain) | |  |
| **Lifestyle History** | | |
| Smoking | | |
| Are you a smoker? | |  |
| If you are an ex-smoker, when did you give up? | |  |
| How many cigarettes do you smoke a day? | |  |
| Alcohol | | |
| How many units of alcohol do you drink each week?  (1 unit = half a pint of beer or cider; a single measure of spirits; a small glass of wine) | |  |
| Any other information? | |  |
| Height: | Weight: | |
| To the best of my knowledge, this is an accurate statement of my health. I understand that medical information that is knowingly withheld, suppressed, or deliberately misleading or false may make me liable, if subsequently employed, to dismissal. I am also aware that if my health changes/ deteriorates in any way whilst engaged through Care24 Recruitment or between assignments, I am required to notify Care24 Recruitment immediately.  I declare that all the above statements are true and complete to the best of my knowledge and behalf. I hereby give Care24 Recruitment Limited the permission to contact my General Practitioner to obtain further information should it be required.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| **Data Protection Statement** |
| The information that you provide on this form and on this form and on any CV give will be used by CN-Care to provide you work finding services. In providing this service to you, you consent to your personal data being included on a computerised database and consent to us transferring your personal details to our clients. We may check the information collects, with third parties or with other information held by us. We may also use or pass information to certain third parties to prevent or detect crime, to protect.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Confidentiality Agreement** |
| During your employment, you may have access to see or hear information of a confidential nature. You are required not to disclose any information, particularly related to client/patient details, medical notes etc. to any unauthorised disciplinary action or dismissal.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Third Party Declaration** |
| I hereby allow any information relating to my registration with CN-Care limited to be shared with relevant third parties. This will be overseen by the governance lead for CN-Care limited.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Working Times Regulations** |
| The Working Times Regulations 1998 (“The Regulations”) require Care 24 Limited (“The Company”) to limit your average weekly working time to 48 hours unless you agree with The Company that the limit shall not apply to you. The Company wished to have an agreement with you. It proposes an agreement (which will apply until terminated by notice) on the basis that:   1. The 48-hour limit on average weekly time will not apply to you. 2. You may terminate the agreement (so that the 48-hour time limit would apply to you) by giving the person at the Company to whom you usually report 4 weeks’ written notice. Under the Regulations, the Company must keep records relating to your working time. This is the case where or not you reach an agreement with the Company’s proposals, please sign below. This document will then be record of Agreement.   **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Revalidation Declaration** |
| I hereby declare that I have read through the Care24 Recruitment Limited revalidation guidance notes. Any breach of obligation may result in disciplinary action or dismissal.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Tax Liabilities (IR35 Contract)** |
| The contractor warrants and represent limited that they are an independent contractor of self-employed status. The Contractor undertake to Care24 Recruitment Limited that they will:   1. Pay all tax National Insurance contributions in relation to payments made to them by CN-Care limited pursuant to their signed agreement; and 2. Indemnify Care24 Recruitment limited in respect of any claims that may be by the relevant authorities against Care24 Recruitment limited in respect of tax, National insurance or similar contributions relating to the services.   **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Declaration** |
| I, the undersigned applicant, hereby declare that the information I have given in this application from is true to the best of my knowledge and belief. I consent to my person data and CV being forwarded to clients. I consent to references being passed onto potential employers. I agree that if I have given any false or misleading information, or do not give relevant information now or in the future, this may result in termination of an assignment without notice. If, during the course of a temporary assignment, the Client wishes to employ me direct, I acknowledge that Care24 Recruitment will be entitled either to charge the client an introduction/transfer fee, or to agree an extension of the hiring period with the Client (after which I may be employed by the Client without further charge being applicable to the Client).  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Drug Calculations: Questions** | |
| Convert 0,125g to mg |  |
| Convert 250 mcg to mg |  |
| If a patient requires 1000 ml in 21 h what is the flow rate? |  |
| If a patient is to be given 750 ml by IVI using a controller with a drip factor of 20 drops/ml over 12 hours, what would you set the drip rate? |  |
| Drugs available as 10 mg/ml: prescription is for  20mg, how many ml will be given? |  |
| Drugs available as 20 mg/5ml: how many mg will be in 7.5 ml? |  |
| Prescription 30 mg/h, you have a bag containing 250 mg in 50 ml, what is the flow rate (ml/h)? |  |
| Prescription 30 mg/h, you have a bag containing 250 mg in 50 ml, what is the flow rate (ml/h)? |  |
| A patient is to be given 1000 ml, drip factor is 15 drops/ml over 8 h. What would you set the drip rate? |  |
| 50 mg prescribed, tablets are 12.5 mg each, how many would you give? |  |
| 1 mg prescribed, tablets are 500 micrograms; how may tablets will you give? |  |

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| **Drug calculations: Formulas** | |
| Dosage Calculations | What you want  What you have got |
| Liquid Calculations | What you want X what it’s in  What you have got |
| Intravenous Infusions | Clear fluid solution set: 20 drops per/ ml  Blood giving set: 15 drops per/ml  Paediatric giving set: 60 drops per/ml  Drop rate=mlh x drops ml  60 min per h |
| Flow rate | Total volume to be infused  Number of h |

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| **List of requirements for General Nurses, Registered Mental Health Nurse, Paeds Nurses, Midwifes and A&E Nurses** | |
| ☐ | 2 proofs of address dated within the last 6 months (utility bills, bank statements, Inland Revenue documents and driving licence. Mobile phone bills are not accepted. |
| ☐ | A CV documenting your 10 year employment history (with dates AND months) |
| ☐ | DBS Application form and payment of £52.98 – (Online Application + Card Payment) if you are registered on the new update service, please bring along your DBS certificate so we can photo copy and do an online check on you. |
| ☐ | Proof of your National Insurance number, please note this must be in the form of your NI card, P45, P60 or other Department of Work and Pensions document. |
| ☐ | NMC Statement of Entry (if you don’t have this document you can request it from the NMC on 02073339333 |
| ☐ | Intention to Practice Document (NMC) |
| ☐ | Nursing qualification (i.e. diploma or a Degree in Nursing |
| ☐ | Midwifery qualification (i.e. diploma or a Degree in Nursing) |
| ☐ | Passport photograph |
| ☐ | Valid Passport /ID Card / Visa if applicable |
| ☐ | Driving license if applicable |
| ☐ | Professional Indemnity Insurance (RCN, RCM, Unison etc.) |
| ☐ | P45 form or a P45 |
| ☐ | Bank details (Welcome letter from bank/Limited Company Certificate & Company account details & Memorandum of Association (LTD’s Only)) |

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| **The Following Mandatory Training Certificates Dated Within the Last 6 Months** | | **Proof of Immunity** | |
| ☐ | Lone Worker | ☐ | Measles |
| ☐ | Safeguarding Vulnerable Adult | ☐ | Rubella |
| ☐ | Safeguarding Vulnerable Children | ☐ | Hepatitis B |
| ☐ | Fire safety | ☐ | TB/BCG |
| ☐ | Health and Safety | ☐ | Varicella/Chicken Pox |
| ☐ | Infection Control | ☐ | Hepatitis C (IVS) (Midwife, A&E Nurse) |
| ☐ | Conflict Resolution | ☐ | Hepatitis B Antigen (IVS) (midwife, A&E Nurse) |
| ☐ | Information Governance | ☐ | HIV 1 & 2 (IVS) (Midwife, A&E Nurse) |
| ☐ | Manual Handling |  |  |
| ☐ | Basic Life Support |  |  |

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| **Additionally, For RMNs, Paeds Nurses, Midwifes and A&E Nurses** | |
| ☐ | Prevention and Management of Violence & Aggression (RMN) |
| ☐ | Safeguarding Vulnerable Adults Level 3 (Midwife, Paeds Nurse, A&E Nurse) |
| ☐ | Safeguarding Vulnerable Children Level 3 (Midwife, Paeds Nurse, A&E Nurse) |
| ☐ | Complaints Handling (Midwife, A&E Nurse) |
| ☐ | Neonatal Resuscitation (Midwife, Paeds Nurse) |
| ☐ | Skills and Drills (Midwife) |
| ☐ | IV Cannulation (A&E Nurse) |
| ☐ | Cannulations and Venepuncture (Midwife) |
| ☐ | CTG Monitoring (Midwife) |