



## PERSONAL DETAILS

Forenames

Title

Please affix  
2 recent  
Photo's here

Surnames

Date of Birth  
/ /

Present Address

Nationality

National Insurance Number

Home Telephone No.

Passport Number  Expiry Date / /

Mobile Telephone No.

Email

Next of Kin

Next of Kin Contact Address

Relationship

Contact Telephone

Emergency Contact Name and Telephone Number if different

Right to work  
I am eligible to work in the UK and does not need a work permit  I am already in possession or a work permit to work in the UK   
I need to obtain a work permit to work in the UK

## QUALIFICATIONS AND TRAINING

RMN  RGN  HCA  NMC PIN No.  Expiry Date / /

Name and Address of Nurse Training School

Moving and Handling  
Date / /

Basic Life Support / CPR  
Date / /

Infection Control  
Date / /

Health and Safety  
Date / /

Qualification

Fire Safety  
Date / /

Food Hygiene  
Date / /

Start Date  
/ /

End Date  
/ /

# EDUCATION

Please give details of your most recent education

Name & Address of School / College / University

Course Name

Start Date  Qualification Achieved  End Date

Name & Address of School / College / University

Course Name

Start Date  Qualification Achieved  End Date

Name & Address of School / College / University

Course Name

Start Date  Qualification Achieved  End Date

# EMPLOYMENT

Please give details of your most recent employment

Name & Address of Employer

Position Held

Start Date  Speciality  End Date

Name & Address of Employer

Position Held

Start Date  Speciality  End Date

Name & Address of Employer

Position Held

Start Date  Speciality  End Date

Name & Address of Employer

Position Held

Start Date  Speciality  End Date

Please indicate your level of competence (4 Being very competent)

### Personal Hygiene

Bath, Shower Assisted Wash

1  2  3  4

Use of Bath Aids

1  2  3  4

Mouth Care (inc. dentures)

1  2  3  4

Care of Feet (exc. Toenails)

1  2  3  4

Shaving

1  2  3  4

Care of Hair

1  2  3  4

Bed Bath

1  2  3  4

Care of Fingernails

1  2  3  4

Care of Eyes

1  2  3  4

### Toileting

Use of Bedpans / Commodes

1  2  3  4

Recording Fluid Balance

1  2  3  4

Emptying a Catheter Bag

1  2  3  4

### Mobility

Care of Incontinent Patient

1  2  3  4

Walking with Aids

1  2  3  4

Use of Hoists

1  2  3  4

Lifting / Handling course completed (written confirmation required)

1  2  3  4

### Other

Report Writing

1  2  3  4

Maintaining Client Confidentially

1  2  3  4

### Observation

Temperature

1  2  3  4

Respiration

1  2  3  4

Blood Pressure

1  2  3  4

Pulse

1  2  3  4

Urine Testing

1  2  3  4

### Nutrition

Preparation of Meals

1  2  3  4

Feeding a Dependent Patient

1  2  3  4

### General

Pressure are care

1  2  3  4

Washing of Personal Laundry

1  2  3  4

Bedmaking: Changing a bed or drawsheet with patient in / on it.

1  2  3  4

Light House Work

1  2  3  4

Shopping

1  2  3  4

Care of Terminally Ill

1  2  3  4

### Experience

General Hospital / Ward

Yes  No

Mental Health Hospital / Ward

Yes  No

Nursing Home

Yes  No

Hospice

Yes  No

Patients with Dementia

Yes  No

## PROFESSIONAL COURSES & TRAINING ATTENDED

Title of Course	Establishment / Training Centre	Date
Moving & Handling	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Basic Life Support / CPR	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Fire Precaution	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Infection Control	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Health & Safety	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
COSHH & RIDDOR	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Food Hygiene	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

## PROFESSIONAL REFERENCES

Please give details of your most recent education not stated before

Previous Employers Name

Their Position

Dates worked by you

Address

Telephone

Previous Employers Name

Their Position

Dates worked by you

Address

Telephone

Because of the nature of the work you are applying, the provisions of section 4(2) of the Rehabilitation of Offenders Act (1974) do not apply by virtue of the Rehabilitation of Offenders Act (1974) (exceptions) (amendment) Order 1986. 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 to the application for positions to which the Order applies.

Have you ever been convicted in any court of any offence?  Yes  No

Do you have any criminal proceedings pending against you?  Yes  No

If yes, please give details:

I acknowledge my responsibility to inform the agency if there are any changes to my health which could impact upon my ability to carry out my required job function or place patients at any risks.

Signed \_\_\_\_\_ Date / /

Print Name

# EQUAL OPPORTUNITY

In compliance with our Equal Opportunity Policy, we are monitoring job applications to make sure discrimination on the grounds of sex, sexual orientation, gender reassignment, race, ethnic origin, religion, marital status, age and disability do not occur. We would be grateful if you would complete and return this form with your employment / job application form.

Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>	
Marital Status	Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other <input type="checkbox"/>	
Ethnic Origin	White British <input type="checkbox"/> White Irish <input type="checkbox"/> White Other <input type="checkbox"/> Black/Black British <input type="checkbox"/> Asian <input type="checkbox"/> Asian British <input type="checkbox"/> Chinese <input type="checkbox"/> Mixed <input type="checkbox"/> Other <input type="checkbox"/>	
Disability	Do you consider yourself to be disabled under the Disability Discrimination Act?  (The Disability Discrimination Act (1995) defines disability as "a physical or mental impairment which has a substantial and adverse effect on a person's ability to carry out day to day activities".)	
	If yes, what is the nature of your disability? (optional)	

## Office use only

Received by <input type="text"/>	Notes
Interviewed by <input type="text"/>	
Received by <input type="text"/>	
NMC <input type="text"/>	
PIN No. <input type="text"/>	Ref 1 Date Applied <input type="text"/> Date Received <input type="text"/>
Checked by <input type="text"/>	Ref 2 Date Applied <input type="text"/> Date Received <input type="text"/>
Post Reg. Certs. <input type="text"/>	

# HEALTH RECORD CHECKS & IMMUNISATION STATUS (Confidential)

All Health Care Workers must go to their GP or Occupational Health Department to have the blood tests or vaccination and all serology must be checked. Please take this document to your General Practitioner / Nurse for completion.  
 Tests for Hepatitis B, Rubella, Varicella, and BCG Scar / TB are mandatory requirements for NHS Health Workers

Name

Address

Post Code  DOB / /

Vaccination	Result	Date	Signature
TB	SCAR SEEN Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
MANTOUX TEST		<input type="text"/> / <input type="text"/> / <input type="text"/>	
HEPATITIS B COURSE 1		<input type="text"/> / <input type="text"/> / <input type="text"/>	
2		<input type="text"/> / <input type="text"/> / <input type="text"/>	
3		<input type="text"/> / <input type="text"/> / <input type="text"/>	
HEPATITIS BOOSTER		<input type="text"/> / <input type="text"/> / <input type="text"/>	
HEPATITIS B LEVEL OF IMMUNITY		<input type="text"/> / <input type="text"/> / <input type="text"/>	
VARICELLA		<input type="text"/> / <input type="text"/> / <input type="text"/>	
VARICELLA VACCINATION		<input type="text"/> / <input type="text"/> / <input type="text"/>	
MMR VACCINATION		<input type="text"/> / <input type="text"/> / <input type="text"/>	
MEASLES ANTIBODY		<input type="text"/> / <input type="text"/> / <input type="text"/>	
MUMPS ANTIBODY		<input type="text"/> / <input type="text"/> / <input type="text"/>	
OTHERS		<input type="text"/> / <input type="text"/> / <input type="text"/>	

Official ID Stamp

Date / /

Signature

Print Name

## HEALTH SECTION

		Yes	No
1	Do you consider yourself to be in good health?	<input type="checkbox"/>	<input type="checkbox"/>
2	Have you suffered or are you suffering from:	<input type="checkbox"/>	<input type="checkbox"/>
3	Asthma, wheezing or allergic condition?	<input type="checkbox"/>	<input type="checkbox"/>
4	Heart problems, hypertension or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
5	Chest problems or TB?	<input type="checkbox"/>	<input type="checkbox"/>
6	Any blackout, disabling giddiness, fainting or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
7	Stress, anxiety, depression or any other mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>
8	Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
9	Speech, hearing or visual difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
10	Skin condition?	<input type="checkbox"/>	<input type="checkbox"/>
11	Back pain, neck pain, joint problems or arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
12	Difficulty bending or lifting?	<input type="checkbox"/>	<input type="checkbox"/>
13	Blood disorders, sickle cell, jaundice or liver problems?	<input type="checkbox"/>	<input type="checkbox"/>
14	Problems with alcohol or drug misuse?	<input type="checkbox"/>	<input type="checkbox"/>
15	Are you receiving any regular medication or regular attention from your GP or at hospital	<input type="checkbox"/>	<input type="checkbox"/>
16	Has any previous work been detrimental to your health?	<input type="checkbox"/>	<input type="checkbox"/>
17	Have you left or been retired from a previous job because of ill health?	<input type="checkbox"/>	<input type="checkbox"/>
18	Have you ever been registered or judged as being disabled?	<input type="checkbox"/>	<input type="checkbox"/>
19	Do you have an impairment which might qualify under the Disability Discrimination Act 1995?	<input type="checkbox"/>	<input type="checkbox"/>
20	Have you left or been retired from a previous position due to a disability?	<input type="checkbox"/>	<input type="checkbox"/>