FOSSE HEALTHCARE

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NHS Qualified

APPLICATION FORM

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Personal Information

Surname:	Forenames:
Maiden Name (if applicable):	Date of Birth:
Nationality:	NI Number:
Home Address: Postcode: Home Tel: Mobile: Email:	**MALE / FEMALE** (circle as appropriate) Next of Kin Name: Relationship: Address: Postcode: Telephone Number:
Are you eligible to work in the UK? **YES / NO** Expiry Date (If applicable):	
What is your qualification (circle as appropriate)? **RNA / RNMH / ODP / MIDWIFE** If other, please specify:	
Are you competent practising the following extended skills: IV Administration: **YES / NO** Cannulation: **YES / NO** Phlebotomy: **YES / NO**	
Do you have a Moving & Handling certificate? **YES / NO** If Yes, Expiry Date:	
Do you have a Basic Life Support certificate? **YES / NO** If Yes, Expiry Date:	
Preferred shifts (circle as appropriate): **EARLIES / LATES / LONG DAYS / NIGHTS**	
On average, how many hours a week do you want to work? **hours**	
Enhanced DBS Certificate Number (if applicable):	
How did you hear about us? (e.g. Google, Facebook, referral)	
Do you have your own transport? **YES / NO**	
How far are you prepared to travel to work? **miles**	

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Professional Nursing/ODP/Midwifery Registrations

Professional Body	Registration Number	Expiry Date (MM/YY)

Professional Qualifications (Relevant to Healthcare / Nursing only)

Qualification	Where Completed	Date From (MM/YY)	Date To (MM/YY)

Only include below additional training you have a valid certificate of attendance for:

Course	Where Completed	Date Completed (DD/MM/YY)	Date Expires (DD/MM/YY)

Current and Previous Employment History

(10 years work history required starting with the <u>most recent first</u>)

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Name & Address of Employer	Dates (DD/MM/YY)	Position/ Job Title	Reason for Leaving	Pay
Name: Address:	From: / / To: / /			
Name: Address:	From: / / To: / /			
Name: Address:	From: / / To: / /			
Name: Address:	From: / / To: / /			
Name: Address:	From: / / To: / /			
Name: Address:	From: / / To: / /			
Name: Address:	From: / / To: / /			
Name: Address:	From: / / To: / /			

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NOTES (eg. gaps in work history):

Do you have any health issues or disabilities that will prevent you from carrying out your duties as a Healthcare Professional to a satisfactory standard?

YES / NO

If yes, what are your needs in terms of reasonable adjustments to enable you to carry out your duties to a satisfactory standard?

Please specify:

Have you been dismissed, had disciplinary action taken against you or been reported to the NMC/HCPC in the PAST 10 years?

YES / NO

Details:

References

(We can only accept work references from Line Managers, not work colleagues. Please use work contact details only, ensuring one reference is from your current or most recent employer. We do not accept personal references. Please note; references must cover a 3 year period).

Name: Position: Company Name: Address: Telephone No: Email:	Name: Position: Company Name: Address: Telephone No: Email:
Name: Position: Company Name: Address: Telephone No: Email:	Name: Position: Company Name: Address: Telephone No: Email:
Name: Position: Company Name: Address: Telephone No: Email:	Name: Position: Company Name: Address: Telephone No: Email:

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Rehabilitation Of Offenders Act 1974

In view of the nature of the work for which you are applying, this post is exempt from the provision of 2.4(2) of the Rehabilitation of Offenders Act 1974 by virtue of the Rehabilitation of Offenders Act (Exceptions) Order 1975. Applicants are, therefore, not entitled to withhold information about convictions, which for other purposes are "spent" under the provision of the Act and, in the event of employment, any failure to disclose such convictions would result in dismissal. Any information given will be completely confidential and will be considered only in relation to this application.

Have you ever been convicted of a criminal offence by a Court of Law (please circle)?

YES / NO

Equal Opportunities

Fosse Healthcare is fully committed to the principle of Equal Opportunities in recruitment irrespective of colour, race, sex, marital status, sexual orientation, ethnic origin, nationality, religion, disability or age.

Declaration

I confirm that I have received a copy of the Staff Handbook and Nurse Disk and will adhere to the conditions and guidance enclosed.

By signing this application I declare that all information given by me is accurate and in no way misleading or false.

SIGNATURE:_____ **DATE:**_____