**Healthcare Application Form**

Please complete in **FULL** and in **BLOCK LETTERS** using black ink or typescript.

Important two passport photographs must be attached.

Position Applied for:............................................................ Date Available: .......................

**Personal Details**

Surname: (Mr./Mrs/Ms./Miss) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Forenames: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maiden Name (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (including postcode): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you lived at this address

Previous address if under 5 year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a disability in accordance with the disability discrimination act 1995? Open box Yes Open box No

If ‘yes’ please state the nature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP / Doctor Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Professional indemnity Insurance: Open box Yes Open box No

If yes Insurance please provide insurance company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Driving License: Open box Yes Open box No

Access to a car: Open box Yes Open box No

Next of kin: (or person to be contacted in the event of illness or an accident):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NMC Pin Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Passport no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you require a visa or work permit please specify the type:

Spouse Open box Ancestry Open box Residency Open box Working Holiday Open box VISA Open box

Visa or works permit expiry date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work permit / Sponsorship / Other: (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Education and training:**

|  |  |  |
| --- | --- | --- |
| Name of Secondary School | Examinations Passed | Date |
| Address:  From:  To: |  |  |
| Name of College/University | Examinations Passed | Date |
| Address:  Intake Date:  Completion Date:  Registration Date: |  |  |

**Access NI Check:**

For the purpose of application for employment, it is out policy to carry out an Access NI check. The purpose of this is to ensure staff are suitable to be appointed to positions were they will be working with vulnerable Children and Adults.

The check will tell whether you have a criminal record, or whether Access NI holds any other information about you which might have a bearing on your suitability. Any information we receive will be treated confidentially, and will discuss with you before we make a final decision.

The rules and guidelines in the access NI code of practise. Further information is available on access NI website. [www.dojni.gov.uk/accessni](http://www.dojni.gov.uk/accessni)

Rehabilitation of offenders (Exemptions Order N.I. 1979). We have a policy on the recruitment of ex-offenders that is available on request at our office.

Please note: Having a criminal record will not necessarily prevent you from working with us.

I have read and understand the above and confirm that there is no reason that prevents me working with Children or Vulnerable Adults.

Open box Yes Open box No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment History** (start with your most current position, including any gaps):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name & Address of Employer | Brief Description of Responsibilities | Dates  From – To | Reasons  for leaving | Salary  Upon Leaving |
|  |  |  |  |  |

Name of Referees: (2 References are required, one from your most recent or present employer.)

All references should be healthcare employment related; character references are not acceptable.

|  |  |
| --- | --- |
| Ref 1:  **Name:**  **Address:**  **Tel. No:**  **Position:** | Ref 2:  **Name:**  **Address:**  **Tel. No:**  **Position:** |

**The Following Courses are Mandatory and Must be updated yearly and copies of Certificates forwarded to be kept on your file.**

|  |  |  |
| --- | --- | --- |
| **Course** | **Certificates** | **Dates Attended** |
| Manual Handling  CPR/First Aid  Infection Control  Dementia Awareness  Safeguarding Vulnerable Adults and Children  Fire Awareness  Conflict Resolution  Basic Food Hygiene | Open box Yes Open box No  Open box Yes Open box No  Open box Yes Open box No  Open box Yes Open box No  Open box Yes Open box No  Open box Yes Open box No  Open box Yes Open box No  Open box Yes Open box No |  |

**Other courses and study days attended** (Start with your most recent)

|  |  |  |
| --- | --- | --- |
| Name of Training Organisation | Title of Course | Date and Duration |
|  |  |  |

Experience

|  |  |  |  |
| --- | --- | --- | --- |
| **Nurses**  Tick where applicable to indicate areas of experience | | | **Care Assistants**  Checklist |
|  |  |  |  |

**Work Preferences:**

|  |  |
| --- | --- |
| Type of work you are available for | Work Preferences |
| Full Time: Open box Yes Open box No  Part Time: Open box Yes Open box No  Evenings: Open box Yes Open box No  Nights: Open box Yes Open box No  Weekends: Open box Yes Open box No | NHS, Nursing Homes, etc ... |
|  | Areas willing to travel to |
|  |  |

I affirm the information given is true and correct. I understand a physical examination may be required and any offer of employment made will be subject to a satisfactory medical report. I also understand that any false information or deliberate omissions may disqualify me from employment or may render me liable to dismissal.

Signed: ..............................................................................

Date: .................................................................................