INSIGNIA healthcare solutions

*excellence in healthcare

please attach photograph here

Application Form

reference number:

Position applied for

Qualified applicants please complete section 2a. Non-qualified please complete section 2b.

1 Personal details

Title (eg. Mr, Mrs, Miss or Ms) Surname

Forenames

Other surnames you have been known by

Date of birth Nationality National Insurance number

Address

Postcode Telephone (home) Telephone (day time)

Mobile number Is it convenient to telephone you at work? yes / no

Email address

Next of kin (to be notified in case of an emergency)

Full name (to include title, surname and forenames)

Address

Postcode Telephone Relationship

2a Professional experience TO BE COMPLETED BY QUALIFIED APPLICANTS ONLY

Are you registered in the UK? yes / no Part of register

Qualification Staff number

NMC Pin/AODP number Pin/AODP expiry date

Professional indemnity insurance

All qualified staff members are required to hold individual professional indemnity insurance to the value of £3 million. Please provide evidence of this.

Name of professional body Membership number

Name of trades unions to which you hold membership

Failure to provide this information may affect assignment of work within the NHS.

Professional experience CONTINUED

Please tick all the nursing specialities of which you have significant experience

- Theatre
- ODPs
- Anaesthetics (eg cardiac, thoracic, neuro, ENT)
- Scrub
- Recovery
- ITU
- HDU
- SCBU
- NICU
- PICU
- CCU
- A&E
- Surgical (eg cardiac, thoracic, neuro, ENT)
- Midwifery
- Burns and Plastic
- Cardiology
- Cardiothoracic
- Clinical Perfusion
- Dermatology
- District/ Community Nursing
- ENT
- Elderly Care
- Family Planning
- Gynaecology
- Haematology
- Health Visiting
- Infectious Diseases
- Liver Unit
- Medical
- Mental Health
- Neurology
- Neonatal Practice Nursing
- Occupational Health
- Oncology
- Opthalmics
- Orthopaedics
- Outpatients
- Paediatrics
- Palliative Care
- Phlebotomy
- Psychiatry
- Radiotherapy
- Renal Dialysis
- School Health
- Venepuncture
- X-ray
- Other, please state:

2b Experience TO BE COMPLETED BY NON-QUALIFIED APPLICANTS

To enable us to asses your experience, please tick the appropriate boxes

- Bath/ shower/ strip wash
- Use of bath aids
- Mouth care (inc. denture care)
- Care of feet (excl. toenails)
- Dressing/ undressing
- Bed bath
- Shaving
- Care of hair
- Care of fingernails
- Care of eyes
- Care of bladder and bowels
- Use of bedpans/ commodes etc
- Emptying catheter bag
- Changing colostomy bag
- Recording fluid balance
- Moving and handling patients
- Use of walking aids
- Use of hoist
- Current moving and handling course
- Bed making
- Changing a bed/ drawsheet with patient in/ on it
- Light housework, washing of personal laundry
- Shopping/ collection of pensions
- Preparation of meals
- Feeding patients
- Recording blood pressure
- Recording temperature
- Care of paediatrics
- In milk kitchens/ bottle feeding
- Care of neonatal
- Portering
- Circulating
- Sterile services
- HDU
- CCU
- Recording respirations
- Weight charts
- Recording pulse
- Urine testing
- Obtaining simple specimens
- Pressure area care
- Ensuring medication has been taken
- Observing changes in patients/ clients and reporting
- Simple dressings
- Assisted with return of patient from operating theatres
- Assisted with Occupational Therapy including sport and play
- Answering the telephone, taking, recording and conveying messages
- Experience of dementia
- Caring for the terminally ill
- Assisted with Last Offices
- Other, please state:

Experience CONTINUED

Are you a

Support worker (Learning Disabilities)? ☐
Care worker (Domiciliary Care)? ☐
Care worker (Care Homes & Hospitals)? ☐
Care Worker (Residential Live-ins)? ☐

3 Work experience and education

Mandatory requirements

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

Training courses	Date of last training	Date update required
Moving and handling		
Fire precautions		
Health and safety (1974/1999 Acts inc COSSH/RIDDOR)		
Infection control		
CPR (including newborns)		
First Aid		
POVA		

Employment

Please give details of your complete employment history. Please include reasons for any gaps.

Name and address of employer	Position	Date from	Date to	Grade	Reason for leaving

Please list any other agencies you are currently working for.

How did you hear about Insignia Healthcare Solutions?

Education

Please give details of your secondary education

School name and address	Dates of attendance	Type of qualification	Subjects	Grades

Please give details of your further education and training

Establishment name and address	Dates of attendance	Type of qualification	Subject	Grade

4 Work preference

- Full time ☐
- Part time ☐
- Weekends ☐
- Weekdays ☐
- Nights ☐
- Occasional weeks ☐

Date available to start

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

Please state the specialised areas in which you feel competent and confident to work

First choice

Second choice

Third choice

5 General information

Do you hold a full current driving licence? yes / no

Do you have a car available? yes / no

Drivers Licence No

Insurer

Car make and model

Car registration no

Do you speak any other languages in addition to English? yes / no If yes:

Language	Written			Spoken		
	Fluent	Good	Fair	Fluent	Good	Fair

6 Declaration of health

Please answer all questions

Have you ever suffered from any of the following:	yes	no	if yes, additional information
Tuberculosis, asthma, bronchitis, german measles, typhoid, dysentery, poliomyelitis, rheumatic fever, jaundice/ hepatitis			
Varicella (chicken pox / shingles)			
Chest pain, heart condition or high or low blood pressure			
Epilepsy, fits, attacks of giddiness, blackouts, fainting, migraine			
Depression, mental illness or nervous breakdown			
Diabetes, thyroid or other gland trouble			
Dermatitis, skin sensitivity (allergies), psoriasis or eczema			
Back or neck injury / problems / pain			
Gastric problems, ulcers, irritable bowel syndrome, kidney or urinary conditions			
Have you any reason to believe you may be infected by any communicable disease?			
Any other current or recent medical condition or treatment which might affect your attendance or performance at work?			
Please give details of any relevant or ongoing medication you are taking			
Any illness, condition or surgical operation that prevented you from attending work or your normal duties or activities for more than one week during the past year?			
Any physical disabilities including defect of sight or hearing?			
Are you registered under the Disabled Persons Act?			
Have you ever been in contact with MRSA or worked in an MRSA environment?			
Are you aware of the need to understand and be screened for MRSA?			
Are you or have you ever been infected with tuberculosis?			
Do you agree to abide by the government guidelines on AIDS/HIV infected healthcare workers? (HSC 1998/266 Guidance on the Management of AIDS/HIV Infected Health Care Workers and Patient Notification)			

Do you agree to being health screened or to obtaining a certificate of fitness from your GP or an Occupational Health Service if required? yes / no

Signed

Date

Name of GP

Address

Telephone number

Record of immunisations

Lab report from Occupational Health Department or letter from GP confirming status is required

Types of immunisation	Yes	No	Date	Results
Tetanus				
Diphtheria Schick test				
Rubella (german measles)				
Poliomyelitis				
Hepatitis B				
Antibodies				
Tuberculosis BCG				
Chest x-ray				
Varicella				

Night shift workers ONLY

Have you worked night shifts in the past? yes / no

What type of work was this?

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

7 References

Please give the names of two professional people of a senior grade/ position to you, including your present or most recent employer or Agency, whom we may approach for a nursing reference. Referees must not be relatives or friends. They must be able to provide a credible comment on your ability to undertake the duties of the post applied for. Home addresses of referees are not acceptable.

Reference 1

Name

Position

Work address

Postcode

Telephone no

Fax no

Was this person senior to you? yes / no

How long has this person know you in a professional context?

Can we contact this referee before interview? yes / no

Reference 2

Name

Position

Work address

Postcode

Telephone no

Fax no

Was this person senior to you? yes / no

How long has this person know you in a professional context?

Can we contact this referee before interview? yes / no

8 Rehabilitation of Offenders Act 1974 and 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 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 yes, please attach details, including dates, on a separate sheet.

The CRB (Criminal Records Bureau) is the executive agency for the Home Office responsible for conducting checks on criminal records. We are a registered body for receipt of CRB disclosure information. NHS Trusts and private sector hospitals and nursing homes 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 CRB disclosure (or that you produce an acceptable original disclosure which you have already obtained). The disclosure will be compared with the information given above and any inconsistencies could invalidate your application or lead to cancellation of your registration with us.

Please sign to confirm you have read and understood this information.

Signed Date

9 Passport and work permits

People with automatic right to work are citizens of the UK, EU, EEA and certain Commonwealth countries.

Do you need permission to work in the UK? yes / no If yes, please answer the following:

Are you visiting the UK on a working holiday? yes / no Do you hold a student visa? yes / no

Do you require a work permit? yes / no If yes, please provide details:

Do you have a valid work permit? yes / no Expiry date

Passport nationality Place of issue

Passport number Date of issue Expiry date

On entering Britain, what entry was put on your passport by immigration? Write in full. Original documentation must be shown.

10 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. Because 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 sign below to confirm you have read and understood this information and indicate your preference by circling as appropriate.

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

Signed Date

11 Data Protection Act 1998 and inspection

We are required to hold personal information on staff eg. National Insurance number, address, qualifications, a mechanism for checking health and fitness including records of immunisation, record of training, annual leave and sickness, two written references and Rehabilitation of Offenders information. From time to time we may be required to release elements of this information in placing you in assignments: please be assured that we would only disclose information that is necessary.

Please complete and sign the declaration below. If you have any concerns, please contact us.

I CONSENT / DO NOT CONSENT to the disclosure of information required to place me on assignments.

Print name _____ Signed _____ Date _____

If you are placed on assignments in NHS Trusts under Framework Agreements, part of the inspection process involves checking that we maintain certain information as described above. Inspectors will need to know that the Company is maintaining the information as we should.

Please complete and sign the declaration below. If you have any concerns, please contact us.

I CONSENT / DO NOT CONSENT to staff having access to information held on my personal file for inspection purposes.

Print name _____ Signed _____ Date _____

Please note: Regulatory bodies such as Social Services, Home Office, Immigration, Care Quality Commission have the right to access personal files for inspection in order to verify compliance with legislation and NCSC regulations.

12 Declaration

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

Print name _____ Qualification (if applic.) _____

Signed _____ Date _____

Please ensure you enclose all relevant documentation

- Two passport photographs ☐
- Proof of identity (birth and marriage certificate, new style photocard driving licence or passport) ☐
- Copy of work permit, visa stamp and entry stamp in your passport for overseas applicants ☐
- Completed abilities form ☐
- Valid lab report of letter from GP regarding your immunisation status ☐
- Relevant certificates of training ☐
- Copy of NMC Pin card/ AODP membership card ☐
- NMC Statement of Entry letter/ ODP certificate ☐
- Proof of National Insurance number ☐
- Completed CRB form or relevant documentation ☐
- Evidence of insurance (qualified applicants) ☐

Office use only

Date Received:

Interview Date:

Interviewer:

Position:

Annual Review Date: