



UnitedMedical

EXCELLENCE + INTEGRITY + PARTNERSHIP

Doctor Application Form



www.unitedmedlimited.co.uk

(Please complete in black pen in BLOCK CAPITALS)

1. Personal Information

Title: Gender: Male Female

First name (as appears on GMC register):

Date of Birth: Surname:

Other names (if any):

Do you hold a current Full UK Driving licence? Yes No
(If so please forward a copy)

Do you have use of a car/motorcycle? Yes No

Please provide two photographs of yourself, signed on the back and two forms of identification
(E.g. household bill showing address, passport etc.)

National Insurance Number:

Current Address:

..... Postcode:

Mobile Telephone: Alternative Telephone Contact:

E-mail Address:

Are you registered/do you wish to register as a limited company? Yes No

Are you Section 12 approved? Yes No

2. Nationality

British/EC National: Yes No

Permanent Resident Status: Yes No

Holder of Work Permit: Yes No

Passport Number: Expiry Date:

Issued At:

3. Next of Kin Information

Name: Relationship:

Current Address:

..... Postcode:

Daytime Tel: Evening Tel: Ext. or Bleep:

E-mail Address: Mobile:

Emergency Contact Details:



4. Professional Registration* (Required)

Name of Society/Union e.g. GMC: Type of Membership:

Renewal Date: Membership Number:

Are you currently under investigation by the GMC or any other organisation? Yes No

Have you ever been investigated by the GMC or any other organisation? Yes No

Have you ever been subject to disciplinary action? Yes No

If yes to any of the above, please give details:

.....

Are you registered with any other professional bodies (e.g. MRCPsych), if so please give details:

.....

5. Professional (Medical) Indemnity Insurance* (Required)

Name of Insurer: Policy Number:

**A legible copy of the certificate must be supplied*

6. Current and Previous Work

Please list your last three years of employment starting with your current or most recent employer. It is important that you explain any gaps in employment of over 3 months in duration. Please continue on a separate sheet if additional space is required.

Name and Address of Hospital/Employer	Position	From (Month/Year)	To (Month/Year)

Continued overleaf.

Name and Address of Hospital/Employer	Position	From (Month/Year)	To (Month/Year)

7. Bank Details

(Please note if you wish to be paid via a LTD Company, United Medical can only accept LTD Company bank account information)

Bank Name: Account Name:

Bank Address:

..... Postcode:

Account Number: Sort Code:

Reference:

8. Appraisal Management

I can confirm that I am aware of the GMC's performance monitoring process and that I have made formal arrangements to be appraised regularly by an appropriately trained medical practitioner entered on the Specialist Register. Yes No

Last appraisal completed:

Appraisal completed by:

Appraisal GMC number (NB Must be on specialist register with a licence to practise):

Appraiser contact details:

Continued on next page.



Next appraisal due:

Name and contact details of a registered medical practitioner who has agreed to act as your current appraiser:

.....
.....

What plans have you made to ensure readiness for Revalidation? *(Please give details)*

.....
.....

9. Education and Training *(Required)*

University/Institution/Training	Qualification	Date of Graduation

**Please supply documentary evidence.*

Date of last Basic Life Support training:

10. Availability to Work

TAX STATUS

Dates from: National Insurance Number:

Shifts *(tick all that apply)*:

Odd Days

Holidays

Weekends

Full Time

Long Term

PAYE LTD. Company

Unique Tax Reference No:

Company Name:

VAT Registered: Yes No

VAT Registration No:

P45 Enclosed: Yes No

P60 Enclosed: Yes No

11. Professional Referees

We require that you hold references relating to your most recent positions.
Please provide contact details for two Consultants whom you have worked with during your two most recent positions. If you are seeking work at Consultant Level, at least one reference must be from a Medical Director

1st Referee

Name: Position:

Organisation: Telephone Number:

Professional Address:

.....

Fax: Email:

Capacity in Which Known:

2nd Referee

Name: Position:

Organisation: Telephone Number:

Professional Address:

.....

Fax: Email:

Capacity in Which Known:

I understand and agree to United Medical providing copies of my references to their clients, for the purposes of finding me assignments.

Signed: Date:

12. International English Language Testing System (IELTS)

If relevant, please tick the box to confirm that you have passed each of the four academic modules of the IELTS test as administered by the British Council, and have provided the original IELTS certificates with this application



13. Equal Opportunities

United Medical are an Equal Opportunity Employer. We therefore ensure all recruitment decisions are based solely on the basis of merit and suitability for the assignment. In order to monitor the effectiveness of our policy, we ask all applicants to provide the information requested below. We thank you for your co-operation.

Please tick as appropriate:

Male Female Age Group: 16-20 21-35 36-49 50+

I consider myself to have a disability: Yes No Please specify (if you wish):

Are you registered disabled? Yes No

Please ensure you read all the categories listed below and tick the appropriate box that best describes your ethnic origin. This is not necessarily the same as your nationality.

Specify if you wish:

White Black-Caribbean Indian Bangladeshi Mixed
Black African Black-Other Pakistani Chinese Other

14. General Practitioner's Details

Name: Telephone:

Address:

..... Postcode:

15. Disclosure and Barring Service Check

As a healthcare worker you must complete an enhanced DBS check. You will be sent an electronic link directly by United Medical for your completion, to ensure the timely processing of this application.

In addition, due to the nature of the work for which you are applying the provision of Section 4 of the Rehabilitation of Offenders Act 1974 does not apply by virtue of the Rehabilitation of Offenders Act 1974 (exceptions) Orders 1975.

You are therefore NOT entitled to withhold information about convictions which for purposes are 'spent' under the provisions of the Act. In the event of employment, any failure to disclose such convictions will result in your removal from our register. Any information you may give will, of course, remain strictly confidential.

United Medical may contact you for your permission to disclose such details if relevant to the position you are applying for.

Have you ever been police checked in the UK or another country? Yes No

If so, why and by whom?

.....

Date you were last police checked:

Have you ever been convicted of a criminal offence? Yes No

If 'yes' to either question, please give details:

.....

Please note that if whilst working for United Medical we receive a DBS Enhanced Disclosure that highlights information you have not declared, then you may be removed from your assignment.

16. Working Time Regulations

The Working Times regulations 1998 ("The Regulations") require United Medical to limit your average weekly working time to 48 hours, unless you agree with us that this limit should not apply to you.

United Medical propose to have an agreement with you, which will apply until terminated by notice, on the basis that:

- a) The 48 hour weekly average working time will not apply to you.
- b) You may terminate this agreement so that the 48 hour working time limit would apply, by giving the person at United Medical to whom you usually report, 4 weeks' written notice.

Under the Regulations, United Medical must keep records relating to your working time. This is the case whether or not you reach an agreement with us about waiving working time limits.

If you accept your proposal, please sign below. This document will then be the record of agreement.

Signed:	Print Name:
Date:	

17. Declarations – Including Mandatory Induction, Information and Training

I declare that I have read and understood United Medical's Locum Handbook, and that I am already trained to NHS standards in all these areas. Should I feel I require further training in any area, I will contact United Medical immediately.

The information contained within this application is to the best of my knowledge a true and complete account, including but not limited to my professional history, criminal convictions, and my medical records. In addition, I give permission to United Medical to have access to my medical records pertinent to my immunisation and blood test history.

I agree that any false or misleading information, or if I do not give relevant information now or in the future, may result in termination of an assignment without notice.

I duly authorise United Medical to verify the information that I have provided, as required, and in the common interests of patient safety. In addition I agree that United Medical may forward to authorised recipients, and in the strictest confidence, confidential details held on my file in relation to my registration, employment and/or Occupational Health Status.

I am not aware of any condition, medical or otherwise, which would affect or limit my employment or performance, other than those declared in my Occupational Health Questionnaire.

In addition I acknowledge receipt of United Medical Terms and Conditions and Locum Handbook and confirm I will abide by the contents of both documents.

I declare that I will notify United Medical of any changes to my circumstances immediately, including but not limited to changes in relation to clinical complaints, clinical competency, criminal investigations, occupational health status and professional registration status.

I acknowledge and confirm that United Medical is authorised to apply for and obtain a Disclosure and Barring Service Check (*including the online status update service check app*) and references from any previous employers and educational establishments.

I acknowledge that my personal details will be stored and handled correctly by United Medical in accordance with the Data Protection Act 1998. However, I agree that they may be made available for audit/review by relevant third parties. (*This is relevant for all information including all documents – DBS, Occupational Health, and References*).

I confirm that I have had an appraisal with the Doctor named in this form, that the appraiser is appropriately trained to complete this appraisal, and that the appraisal was completed in line with the approved NHS appraisal system.

Signed:	Print Name:
Date:	