



# UnitedMedical

EXCELLENCE + INTEGRITY + PARTNERSHIP

## Nurse / Allied Health Worker Application Form



United Medical is committed to equal opportunities in all areas of our operations and welcomes all applicants irrespective of sex, sexual orientation, race, age, marital status or disability. The information that you provide on this application form will be used solely to assess your ability to carry out a particular role. If you have any special requirements in terms of this application process or role with us then please advise us and we will be happy to help.

*(Please complete in black pen in BLOCK CAPITALS)*

## 1. Personal Information

Mr  Mrs  Miss  Ms  Dr  Other  please state: .....

Surname: ..... Forename(s): .....

Have you ever been known by another name – if so please specify: .....

Position applied for: .....

Permanent address: .....

..... Postcode: .....

Telephone Home: ..... Work: .....

Mobile: ..... Email: .....

Date of Birth: ..... National Insurance Number: .....

Professional Registration No: ..... Date Registered: ..... Expiry Date: .....

NMC Pin No (nurses): ..... Date Registered: ..... Expiry Date: .....

Are there any fitness to practise issues with your registration(s) Yes  No

If yes, please explain: .....

Languages Spoken: ..... Level of proficiency: .....

Do you hold a full current driving licence? Yes  No

Give details of any endorsements: .....

Do you have regular use of a: Car  Motorcycle  Bicycle

## 2. Emergency Contact

Name: .....

Relationship: ..... Telephone Number: .....

## 3. Right to Work in The UK

Do you have a right to work in the UK? Yes  No

Can you provide documentation to support this if required? Yes  No

Nationality: .....



## 4. Work Preferences

Dates you are free to work from: ..... To: .....

Full Time  Part Time  Emergency  Weekend  Evenings

Work preferences / type of work wanted: .....

## 5. Further Education

Where applicable, please include details of examinations which have been or are about to be taken but results of which are not yet available.

University/Institution/Training	Qualification	Date of Graduation

## 6. Professional Qualifications

Awarding Body/Institution	Qualification	Grade/Class (if applicable)	Date Obtained

## 7. Employment History

Please Provide details of all your employment starting with the most recent / current position, and any gaps for the last 10 years. College leavers must provide details of vacation employment. If necessary continue on a separate sheet.

Employer/Organisation	Dates From - To	Position/Grade	Salary/Hourly Rate	Reason for Leaving

Please provide details of duties and responsibilities, giving as much detail as possible:

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.....

.....

*Continued overleaf.*

Employer/Organisation	Dates From - To	Position/Grade	Salary/Hourly Rate	Reason for Leaving

Please provide details of duties and responsibilities, giving as much detail as possible:

.....

.....

.....

Employer/Organisation	Dates From - To	Position/Grade	Salary/Hourly Rate	Reason for Leaving

Please provide details of duties and responsibilities, giving as much detail as possible:

.....

.....

.....

Employer/Organisation	Dates From - To	Position/Grade	Salary/Hourly Rate	Reason for Leaving

Please provide details of duties and responsibilities, giving as much detail as possible:

.....

.....

.....

Any gaps in employment? Yes  No

Please provide details of any gaps in employment: .....

.....

.....

.....

Please use this space to give any other information you consider to be relevant, including any reasons why you consider yourself a suitable candidate for this position (*continue on a separate sheet if necessary*):

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.....

.....



## 8. References

Please ensure your most recent employer is 1st Referee - THIS IS VERY IMPORTANT.

Please supply the name and addresses of at least two people (*not relatives*) whom we may contact for references. One of these should be your most recent employer and be someone of a senior capacity.

### 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: .....

## 9. Disciplinary & Criminal Issues

As a healthcare worker you must complete a DBS check. In addition, due to the nature of the work for which you are applying, you are NOT entitled to withhold information about convictions which under other circumstances are regarded as 'spent' under the provisions of the Rehabilitation of Offenders Act 1974.

The information will be treated in confidence and only taken into account where, in the reasonable opinion of United Medical, the offence is relevant to the post for which you are applying. Failure to declare a conviction may require us to remove you from our register or terminate an assignment if the offence later comes to light.

Have you ever been convicted of ANY criminal offence? Yes  No  If yes list details below:

.....

.....

.....

I hereby give consent for you to liaise with other agencies for example, police, social services, probation service

Yes  No

## 10. Declaration & Confidentiality Agreement

I declare that the details, which I have given are true.

I understand that providing misleading or false information to support my application will disqualify me from registration. I hereby declare that I have understood and complied with the requirements laid down in the previous paragraph and I agree that the information given on this form may be used for registered purposes under the Data Protection Act 1984.

Signed: .....	Print Name: .....
Date: .....	

## 11. Working Time Regulations

You are not required to work for more than an average of 48 hours per week. Only sign the following statement if you wish to be able to work for more than 48 hours per week.

I, ....., who lives at: .....

.....

do agree that I may work for longer than the average 48 hours per week, if I change my mind I will give my employer and/or agency not less than one week's notice in writing to end this agreement.

Signed: .....	Date: .....
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## 12. Equal Opportunities Monitoring Form

*(This information remains private and confidential. Please complete in full)*

United Medical has an equal opportunities policy to ensure that all applicants are treated fairly and are appointed solely on their suitability for the post. All stages of the recruitment are monitored to ensure that unfair discrimination is not taking place.

For the sole purpose of monitoring our policy, as stated above, please complete the following

Gender: Male  Female

Age Band: Under 30  30-39  40-49  50-59  60-69  70 or over

Do you consider yourself to have a disability? Yes  No

If yes, please state nature: .....

Are you registered disabled? Yes  No

If yes, please state Reg. No: .....

### Your Ethnic Origin

Please indicate your ethnic group:

White <input type="checkbox"/>	Black-Caribbean <input type="checkbox"/>	Indian <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Mixed <input type="checkbox"/>
Black African <input type="checkbox"/>	Black-Other <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Chinese <input type="checkbox"/>	Other <input type="checkbox"/>



### 13. 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: .....

### 14. Permission

I give United Medical permission to give copies of my documents, submitted to them, to the hospitals that may require the same information for purposes of auditing or recruitment.

Signed: .....	Print Name: .....
Date: .....	ABA Pin: .....
PPS No: .....	

### 15. Agreement

I am aware that I am responsible for ensuring that my Manual Handling, Non Violent Crisis Intervention Training, CPR, Infection Prevention & Control, Waste Management and Decontamination issues, Personal Protection are kept up to date.

I am also aware that where relevant to my work I am personally responsible for ensuring that I have proof of immunity against Hepatitis B, Varicella (*chicken pox*) and Tuberculosis. I will keep a check on my Hepatitis B antibodies level as required, and I will not put anyone at risk by not doing so.

I declare that I will never make myself available for work if I am sick or am on sick leave from any other establishment.

I am aware of my obligations under The Working Time Act.

I am also aware that my main employer has the right to ask United Medical for a list of my hours worked with United Medical.

I am aware that United Medical cannot guarantee shifts and that the rates may vary from client to client and United Medical do not set the rates but will endeavour to get the best possible.

I am aware that payments will be withheld in the event of my requirements being out of date until such time as I update them.

Signed: .....	Print Name: .....
Qualification: .....	Date: .....

## 16. Confidential Disclosure Agreement

Confidential Disclosure agreement between United Medical and all nurses/carers and support workers who carry out assignments/shifts or work in HSE Locations, All Hospitals, Nursing Homes, Private Homes or any other Location.

I the undersigned shall regard as confidential and shall not disclose to any person, other than a person authorised, any information acquired by me concerning the HSE/all other locations, its staff or procedures; concerning the identity of any patient at HSE/all of locations premises or concerning the medical condition of or treatment received by any such patient. I undertake never to discuss patients, their families or otherwise with anybody other than an authorised person.

I accept that any breach of confidentiality may be pursued through the legal system or in the case of a nurse may be referred to "fitness to practise" within NMC.

I am aware of the need for an up to date DBS. I also undertake to inform United Medical immediately if any new court case proceedings are commenced or convictions recorded against me.

I undertake and agree to inform United Medical immediately if I come in contact with any clinical risk or if I pose a risk to patient or staff safety.

I accept that I will at no point become an employee of the HSE/United Medical or any location where I am assigned by United Medical irrespective of however long I am placed there, but the HSE/or any location will provide supervision and I will be under their direction and control for the duration of the shift.

I accept that if there are any disputes of any nature that they will be dealt with by United Medical and not by the HSE/or any location where I am placed. I understand and accept that United Medical has the right to relocate me any time.

I the undersigned shall regard as confidential and shall not disclose to any person any information regarding United Medical, its staff, its clients or procedures to any unauthorised person.

Signed: .....	Print Name: .....
Date: .....	

## 17. References Check Declaration

### To Whom It May Concern

I (print name) : .....

give permission to United Medical to confirm reference letters with the referees and to validate my passport with the Passport Office and immigration. I agree that United Medical can send me text and emails regarding jobs and relevant information.

give my permission to United Medical to give copies of relevant documents to the relevant appraisal bodies including HSE or Auditing purposes.

give permission to United Medical to give my timesheets to Clients for auditing purposes and for the purpose of verification of signatures and to authorise payment.

Are there any fitness to practise issues with your registrations? Yes  No

Signed: .....	Print Name: .....
Date: .....	

## 18. Voluntary Experience

Please detail any relevant voluntary experience that you have on a separate sheet of paper and send it along with this form.