JOB APPLICATION FORM

Job applied for: ……	Please return to
Reference Number: ……..	Grosvenor House, 11 St Paul's Square, Birmingham, West Midlands|B3 1RB or email support@4seasonshealthcare.co.uk

Surname:……	Preferred title: Please select Mr/ Mrs/ Miss/ Ms
First names: ……	National Insurance No: ……..
Address: ……	Home telephone number: ……..
…….	Mobile telephone number: ……..
Town: ……..	Work telephone number: ……..
Post code: ……	Email address: ……

Permission to work in the UK Employers need to know if it is legal for you to work in the UK. You will need to show proof of your right to work.

Do you need permission to work in the UK? ☐ Yes ☐ No

For more information on working in the UK please see www.gov.uk (visas and immigration)

Preferred Contact Method ……..

Are you willing to work Early shifts ☐ Yes ☐ No

Are you willing to accept late night calls ☐ Yes ☐ No

Please tick the specialities of which you have significant, post training experience. Please remember you have held accountable for any missing information.

SPCIALISM (Nursing)	LESS THAN 6 MONTHS	MORE THAN 6 MONTHS	1- 2 YEARS	2 YEARS +
Medical				
Learning Disability				
ITU Psychiatric				
Intensive Care Unit				
In charge Duties				
Hospitals				
Hospices				
Home Care				
High dependency Unit				
Health Visitors				
Haematology				
Gynaecology				
GU Med				
District Nursing				
Urology				

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Mental Health				
Stoma Care				
Theatre				
Renal				
Residential Homes				
Paediatric				
Oncology				
Midwifery				
Nursing Homes				
Out patients				
CSSD				
Neonatal				
Care of the elderly				
Practice Nurse				
GU Med				
Recovery				
Prisons				
Surgical				
Occupational Health				
Mental health				
Orthopaedics				
PICU				
SCBU				
A & E				
Cardiac				
ODP /ODA				
Neurology				
Radiology				
Scrub				
Theatre				
Day Surgery				
Intensive Care Unit				
School Nurse				
Ante Natal				
Cardiothoracic				
Chemotherapy				
Anaesthetic Trained				
Medical Assess unit				

MID WIVES ONLY

Midwives please circle the appropriate box if practising Yes ☐ No ☐

Intention to practice completed?: Yes ☐ No ☐

Expiration Date / /

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Present/Most Recent Employer

Job title……	Date appointed …… dd/mm/yyyy)
Employer ……..	Salary range……
Address……	Present salary……
……	Notice period ……
Town ……	Date of leaving ……
Post code……..	Reason for leaving ……

Describe the main activities of your present/most recent job

(further details can be provided in your supporting information)

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Previous Employment (most recent first)		
Actual Dates From To	**Employers Address**	**Reason for Leaving**

Referees (Please provide 2 referees)

Present Employer ☐ tick if you don't want us to contact prior to interview	**Previous employer**
Name ……..	Name ……..
Occupation ……..	Occupation ……..
Address ……..	Address ……..
……..	……..
Postcode ……..	Postcode ……..
Email address ……..	Email address ……..
Please note that one of the referees MUST be your current/ most recent employer	

Other information

Do you hold a valid driving licence? ☐Yes ☐No

If yes, please specify type: ……

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Educational/Professional/Vocational qualifications

Qualifications eg, GCSE; A level; NVQs; Degree; Professional qualifications	Subjects	Grade	Date Gained

Membership of Professional Institutions

(State level and date of Membership and whether gained by examination where applicable)

HCPC/ NMC Pin Number: ……..

Registration Date ……..Expiry Date ……..

Other (Please state)

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Job related training

(give details Of any training courses attended)

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Health Declaration

Have you been vaccinated or tested against the following:	YES	NO	DETAILS (Plus dates if YES)
Hepatitis B			
HIV			
Tetanus			

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Poliomyelitis			
Typhoid			
Rubella (German Measles)			
Tuberculosis and BCG			
Hepatitis B Antibodies			
Mantoux, tine or Heaf			
Varicella			
Last X-ray			
Others (Specify)			
Do you or have you at anytime suffered from any of the following	YES	NO	Details. (required if YES)
Skin complaints- dermatitis, Psoriasis, Eczema			
Diabetes or glandular complaints			
Headaches or Migraine			
Hypertension/ heart problems/ similar illness			
Back pains / Back injury or problems			
Jaundice / Hepatitis			
Epilepsy or fainting attacks			
Pleurisy /Bronchitis / Pneumonia			
Asthma			
Infections - ear / sore throat			
Psychiatric illness - Mental disorder/ depression etc			
At present are you having any injections/medications	YES	NO	Details (if YES)
Are you under any treatment of any kind of condition?			
Have you had any major operations			
Physical Disabilities?			
How much time have you taken off work in the last 5 years due to illness?.			
Please state any other information about your health which may affect your work			
If you do not have vaccination information, please provide details of where we can request them below.			

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I certify the above information is correct and hereby give permission to **4 Seasons Healthcare Professionals** to request a further report from my GP/ Occupational Health/ Hospital for clarification if required and for my health report.

GP /Occupational health/ Hospital .....

Address .....

Tel: ..... Mobile .....

Email address: .....

Signed (Applicant) .....

Work Preference

Please specify the kind of Care work are you interested in? (tick all that apply)

NHS ..... Private Hospital ..... Nursing Home .....
Residential Home: ..... Others .....
(Please specify) Short Term ..... Long Term .....

Please indicate when you would like to work. Please tick all relevant boxes.

DAILY.

Part-Time ..... Full-Time ..... Bank Holidays .....
Evenings (M-F) ..... Days (M-F) ..... Nights (M-F) .....
Evenings (Sat-Sun) ..... Days (Sat-Sun) ..... Nights (Sat-Sun) .....

AVALIBILITY

From when are you available to work ..... Come for an interview? .....
Do you have any holiday booked? ..... When: .....

REHABILITATION OF OFFENDERS ACT 1974.

Because of the nature of the work for which you are applying, this post is exempt from the provisions of section 4.2 Rehabilitation of Offenders Act 1974 (Exemption Order 1975). Applicants are therefore, entitled to withhold information about convictions, which for other purposes are 'spent' under the provision of the Act in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action. Information provided will be kept confidential and use in relationship to the post applied for.

Have you ever been convicted of a criminal offence?

YES ☐ NO ☐

If yes, please specify .....

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Do you have any spent or unspent convictions YES ☐ NO ☐

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If yes please specify .....

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Have you instigated an enhanced disclosure within the last six years? YES ☐ NO ☐

I consent to 4 Seasons Healthcare Professionals checking the details I have provided against the various data sources in order to verify my identity and process this application. These details maybe use to assist other organisation such as DBS, NMC in identity purposes.

SIGNATURE DATED

Bank/ Building Society Details

Bank Name .....

Bank Address .....

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Building Society Bank Roll .....

Holders Account Name .....

Sort Code ..... Account No .....

I authorise **4 Seasons Healthcare Professionals** to pay my weekly wages into the above bank account and I will notify **4 Seasons Healthcare Professionals** to if changes occur to my details.

Signed Date

NEXT OF KIN

Name of Emergency contact ..... Relationship to you: .....

Address: .....

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Post code: ..... Home Telephone: ..... Work No: .....

Email Address: .....

Mobile Number/ Landline : .....

Working Time Regulations

I have read and understood the Working Time Regulations and I hereby consent that the working time limit shall not apply to my assignments

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

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Final Statement

I declare that the information provided on this application is true to the best of my knowledge. I have read the terms and condition of engagement and agree to comply with the current Health and Safety at Work Act. I understand that my appointment is subject to the receipt of two satisfactory references and it subject to Enhanced DBS Disclosure. 4 Seasons Healthcare Professionals is free to make any other enquiries thy may find necessary relating to my application. I agree to respect the confidentiality of patients and clients and any other information I may have access to.

Signed Date

4 Seasons Healthcare Professionals OFFICE USE

CHECKLIST		NOTES
Application		
Proof of Address	Utility bills, bank statements, others.	
Proof of identity	Passport, driving license others	
Eligibility to work	Visa, Work Permit,, passport, birth cert	
NMC Pin No		
CRB Application		
48 hours apt out		
PAYE Form		
2 passport photographs		
Immunisation		
Signed contract		

4 Seasons Healthcare Professionals SIGN OFF

I Certify that I interviewed the above applicant in accordance to 4 Seasons Healthcare Professionals requirements and I am satisfied that this applicant is cleared for work.

Name Of Consultant .....
Signature Of Consultant .....
Date .....