DESLA CARE AGENCY

Application Form - Nurse

R002

FIELDS MARKED WITH * ARE APPLICABLE FOR NURSES ONLY, PLEASE LEAVE THESE BLANK IF YOU ARE NOT A NURSE.

About You, Your Work and Payment Details
Please write clearly in BLOCK CAPITALS using black ink

About You

Surname		Title (Mr/Mrs/Miss/Ms)	
First Name(s)		Male ☐ Female ☐	
Marital status		Date of Birth	
National Insurance No			
Current Address			
Post Code			
Mobile Phone		Home Phone	
E-mail			
Do you drive	Yes ☐ No ☐	How do you usually travel to work	

Next of Kin

Name of Next of Kin		Relationship	
Phone Number			
Your Signature		Date	

About Your Work

Job Title			
Speciality 1		Speciality 2	Speciality 3
Current Place of Work		Full Time ☐ Part Time ☐ Days ☐ Nights ☐	

Your Payment Details

Name of Bank/Building Society			
Account Name		Personal ☐ LTD ☐	
Branch Address & Post Code			
Account No		Sort Code	

Your Training, Qualifications, Appraisals and References

Please enclose, with your application a copy of your registration and membership card

*Nurses	NMC Number		RCN Number		Band	
*ODPS	HPC Number		Additional Information			

Mandatory Training

Please tick if you have completed the following training within the last 12 months

Please enclose copies of your training certificates

Moving and Handling	☐	Basic Life Support	☐	Intermediate Life Support	☐	Advanced Life Support	☐
Complaints Handling	☐	Handling Violence and Aggression	☐	Fire Safety	☐	COSHH	☐
RIDDOR	☐	Caldicott Protocols	☐	Data Protection	☐	Infection Control	☐
Lone Worker Training	☐	Equality & Inclusion	☐	Food Hygiene (where required to handle food)	☐	Personal Safety (Mental Health & Learning Dis')	☐
Resuscitation of the Newborn (Midwifery)	☐	Interpretation of Cardiotocograph Traces (Midwifery)	☐	Practical	☐		

*Appraisals

In order to work in the NHS you will need to be appraised annually by a Senior Practitioner of the same discipline, this person will become your "appraiser" Please give details below of the Senior Practitioner who you have made arrangements with to act as your appraiser.

Please give the date of your last appraisal			
Name of Appraiser		Position and Grade of Appraiser	
Branch Address Post Code			
Phone Number		E-mail	

Education and Professional Qualifications

(Original documents as proof of qualification will be required at interview)

Secondary School / College / University	Examinations taken	Result

References

Please supply us with two professional referees. One must be from your present or most recent employer and must be a senior grade to yourself and you must have worked for that person for a period of not less than three months duration.

1. Name		Position	
Work Address Post Code			
Work E-mail		Tel	Fax
2. Name		Position	
Work Address Post Code			
Work E-mail		Tel	Fax

Your DBS status and Uniform

Please send a copy of your most recent DBS Disclosure (formally known as CRB)

Current DBS Disclosure (formally known as CRB)	Yes ☐ No ☐	Clear Yes ☐ No ☐
Issue Date		Disclosure Number
Is this certificate registered with the update service	Yes ☐ No ☐	

All applications who cannot provide a registered DBS or full immunisation record will be required to complete at their own cost. Desla Care Agency will cover the cost of any Mandatory Training updates however cancellations outside of 48 hours and late attendances will be charged to the candidate.

Candidates will be required to purchase uniform if required at the cost of £20 this will be deducted from your timesheet once you have started working through us. Please fill in the box below stating your uniform size and quantity.

Female	8	10	12	14	16	18	20	22	24	26	28
Nurse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
HCA/CH	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Midwife	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Male	38	40	42	44	46	48	50
Nurse	☐	☐	☐	☐	☐	☐	☐
HCA/CH	☐	☐	☐	☐	☐	☐	☐
Midwife	☐	☐	☐	☐	☐	☐	☐

Your Work History

Please ensure you complete this section even if you have a CV. The "Employment history should be recorded on an Application Form which is signed" Please ensure that you leave no gaps unac-counted for and it covers full work history including your education. Please use extra paper if required.

Full work history including your education

Dates to and from are shown in a mm/yy format

Dates are continual with NO gaps

Where there have been gaps in work history please state the reason for the gaps

Lists all relevant training undertaken

From	To	Employer
Title of Post		Grade
From	To	Employer
Title of Post		Grade
From	To	Employer
Title of Post		Grade
From	To	Employer
Title of Post		Grade

Your Declarations

1. Working Time Regulations

For the purposes of the Working Time Regulations 1998 (as amended) I, consent to work in excess of an average of 48 hours per week, averaged over 17 weeks. I understand that I may withdraw this consent by giving Desla Care Agency not less than three months' notice at any time.

Signed	Print Name	Date

In addition, I also consent to work in excess of the maximum number of hours permitted to work at night under the directive. Please note you are under no obligation to sign either declaration.

Signed	Print Name	Date

2. Health Declaration

All applicants must complete the enclosed health questionnaire to enable us to establish your fitness for work. We would ask all OVERSEAS candidates to provide a medical statement from their GP or medical department confirming your state of health. Your details will be passed to our Occupational Health Doctors to establish your fitness for work. Please sign the declaration below to allow Desla Care Agency to release your information for inspection.

I (name) _____ consent to Desla Care Agency . Recruitment releasing my health and immunisation records for review to Desla Care Agency qualified Occupational Health Advisor. I understand that based on this review I may be required to undergo a medical examination to establish my fitness for work. I confirm that I will immediately inform Desla Care Agency . Recruitment in confidence if I am HIV Positive, HepB positive or if I have AIDS in accordance with the Department of Health guidelines. I am aware of my obligations regarding MRSA contact and the need for screening. I agree to immediately inform Desla Care Agency . Recruitment should my general condition of health change. I will inform Day Desla Care Agency . Recruitment immediately if I discover that I am pregnant. I understand that withholding information or giving false answers may lead to dismissal. I also hereby consent to Desla Care Agency . obtaining further information regarding my health from my GP or Occupational Health Department.

3. Personal Declaration

I hereby confirm that the information provided on my application is correct and true to the best of my knowledge and that I have not withheld any information that should be taken into account when offering me work.

I understand that providing false or inaccurate information may result in the termination of any placement.

I agree that I will make best endeavors to make myself aware of the Health & Safety procedures for each client I am assigned to.

I confirm that I have read and understood the Terms of Engagement and the terms of the declaration and agree to be bound by them.

4. Confidentiality

I hereby declare that at no time will I divulge to any person, nor use for my own or any other person's benefit, any confidential information in relation to the Client or the Company Desla Care Agency Recruitment) or in relation to any of their employees, business affairs, transactions or finances which I may acquire during the term of my agreement with the Company (Desla Care Agency) under the Terms of Engagement.

5. Rehabilitation of Offenders Act 1974 – Please Answer All Five Questions

Because of the nature of the work for which you are applying , Section 4(2), and further Orders made by the Secretary of State under the provision of this section of the Rehabilitation of Offenders Act (1974) (Exceptions) Order 1975 apply. Applicants are therefore required to give information about convictions which for other purposes are "spent" under the provisions of the Act. Any information given will be completely confidential and will be considered only in relation for positions to which the order applies.

1	Do you have any convictions, cautions or bind overs? If yes please give details...	Yes ☐	No ☐
2	Have you ever had disciplinary action taken against you? If yes please give details...	Yes ☐	No ☐
3	Are you at present the subject of criminal charges or disciplinary action? If yes please give details...	Yes ☐	No ☐
4	Do you agree for Desla Care Agency to check the status of your DBS by performing an online check at any time during your employment? (for candidate registered on the update service only)	Yes ☐	No ☐
5	Do you consent to Desla Care Agency requesting a police (DBS) or any appropriate references on your behalf?	Yes ☐	No ☐

6. Right To Work in the UK

Please complete this form, regardless of your nationality, as it is a legal requirement. If you are an overseas national or require a work permit to work in the UK please include copies of supporting documentation.

Your entitlement for working in the UK is based upon what status:

EU Citizen	☐	Spouse of an EU Citizen	☐	Work Permit	☐
Permit-free Visa	☐	Right of Abode in the UK	☐	Admitted to UK as Doctor Prior to 1985	☐

7. Health and Safety

Each agency worker has a responsibility at the start of their first shift to become familiar with the Client's general policies including, without limitation, those relating to Crash Call Procedures, the Hot Spot Mechanism for alerting security sta that an individual is in trouble, Fire Policy and the Violent Episode Policy.

8. I.D. And Indemnity Verification

NB Nurses & ODP's only: Please tick this box to confirm you hold your own indemnity insurance.

All Nurses need to have in place an indemnity arrangement as a mandatory requirement of the NMC Code.

It is the professional responsibility of each nurse and midwife to ensure that they have cover which is appropriate to their role and scope of practice and its risks. It is your sole responsibility to ensure that indemnity insurance does not expire.

The cover that they have in place should be relevant to the risks involved in their practice, so that it is reasonably sufficient in the event that a claim is successfully made against them.

I give consent for Desla Care Agency to use an identification document scanner required for NHS frameworks.

Registration Form Declaration

Please Read Before Signing

I declare that by signing this form I am agreeing to declarations 2-8. I am stating that I am legally entitled or allowed to work in the United Kingdom, with or without necessary permission from the Home Office or any other relevant authority. If I have secured permission to work, I have included copies of all documentation. I also acknowledge that if it is found that I am working without the relevant permission, my employment will be terminated with immediate effect and all details passed to the relevant authorities.

I agree that Desla Care Agency retains the right to hold this registration form and any other data required to process it and pass onto any authorised third party and the details held within. I also agree to use all reasonable efforts to assist to comply with the Data Protection Act 2018.

In addition, I confirm that that all the information provided is true and accurate and that I have received and agree to Desla Care Agency Recruitment terms of engagement and Staff Handbook.

Signed		Print Name	Date

You will be requested to update your details annually

New Employee Medical Questionnaire

CONFIDENTIAL

The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake the duties of the post you have been offered or place you at any risk in the workplace. We may recommend adjustments or assistance as a result of this assessment to enable you to do the job. Our aim is to promote and maintain the health of all people at work. Before health clearance is given for employment you may be contacted by the Healthier Business UK Ltd and may need to be seen by an occupational health advisor or physician.

Personal Information

Title	Surname	First names	DOB

Home Tel		Work Tel		Mobile	
Home Address		GP Address			

Medical History

All staff groups complete this section	Yes	No
Do you have any illness/impairment/disability (physical or psychological) which may affect your work	☐	☐
Have you ever had any illness/impairment/disability which may have been caused or made worse by your work	☐	☐
Are you having, or waiting for treatment (including medication) or investigations at present? If your answer is yes, please provide further details of the condition, treatment and dates	☐	☐
Do you think you may need any adjustments or assistance to help you to do the job	☐	☐

Additional Information (If you have answered yes to any questions above please provide additional information below)

Tuberculosis

Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006)	Yes	No
Have you lived continuously in the UK for the last 5 years	☐	☐
If you answered no above, please list all of the countries that you have lived in over the last 5 years		

Have you had a BCG vaccination in relation to Tuberculosis	☐	☐
If you answered yes please state when Date		
Do you have any of the following	☐	☐
A cough which has lasted for more than 3 weeks	☐	☐
Unexplained weight loss	☐	☐
Unexplained fever	☐	☐
Have you had tuberculosis (TB) or been in recent contact with open TB	☐	☐

Additional Information (If you have answered yes to any questions above please provide additional information below)

Chicken Pox or Shingles

	Yes	No	Date
Have you ever had chicken pox or shingles	☐	☐	

Immunisation History

Have you had any of the following immunisations	Yes	No	Date
Triple vaccination as a child (Diptheria / Tetanus / Whooping cough)	☐	☐	
Polio	☐	☐	
Tetanus	☐	☐	
Hepatitis B (If Yes is ticked please give dates below)	☐	☐	

Course	1		2		3	
Course	1		2		3	

Proof of Immunity (please send the following)

Varicella	You must provide a written statement to confirm that you have had chicken pox or shingles however we strongly advise that you provide serology test result showing varicella immunity
Tuberculosis	We require an occupational health/GP certificate of a positive scar or a record of a positive skin test result (Do not Self Declare)
Rubella, Measles & Mumps	Certificate of "two" MMR vaccinations or proof of a positive antibody for Rubella Measles & Mumps
Hepatitis B	You must provide a copy of the most recent pathology report showing titre levels of 100Iu/l or above

Proof of Immunity (Please send the following) EPP Candidates Only

Hepatitis B Surface Antigen	Evidence of a negative Surface Antigen Test Report must be an identified validated sample. (IVS)
Hepatitis C	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)
HIV	Evidence of a negative antibody test Report must be an identified validated s ample. (IVS)

Exposure Prone Procedures

	Yes	No
Will your role involve Exposure Prone Procedures	☐	☐

Declaration

I declare that the answers to the above questions are true and complete to the best of my knowledge and belief. I also give consent for the Healthier Business UK Ltd to make recommendations to my employer.

Signed		Print Name	Date

Equal Opportunities Monitoring

This section of the application will be detached and used for monitoring purposes only. Our organisation recognise and actively promote the benefits of a diverse workforce and are committed to treating all employees with dignity and respect regardless of race, gender, disability, age, sexual orientation religion or belief. We welcome applications from all sections of the community.

Date of Birth:	
Gender	☐ Male ☐ Female ☐ I do not wish to disclose this

Race Relations (Amendment) 2000

I would describe my ethnic origin as (please indicate with a ☑):

Asian or Asian British	**Mixed Raced**	**Other Ethnic Group**
☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Any other Asian background **Black or Black British** ☐ African ☐ Caribbean ☐ Any other Black background	☐ White & Asian ☐ White & Black African ☐ White & Black Caribbean ☐ Any other missed background **White** ☐ British ☐ Irish ☐ Any other white background	☐ Chinese ☐ Any other ethnic group ☐ I do not want to disclose this

Employment Equality Regulations 2003

I Please select the option which best Please indicate your religion or belief describes your sexuality.

☐ Lesbian ☐ Gay ☐ Bisexual ☐ Heterosexual	☐ I do not wish to disclose this	☐ Atheism ☐ Buddhism ☐ Christianity ☐ Islam ☐ Jainism ☐ Sikhism	☐ Judaism ☐ Hinduism ☐ Other ☐ I do not wish to disclose this

Your Registration Checklist

To complete your registration you will be required to provide the following documentation

- [ ] Completed Registration Form – signed in all requested areas
- [ ] Completed Health Questionnaire – signed
- [ ] CV – E-mailed in word format – Your CV must cover full work history from education
- [ ] Your Right to Work in the UK as well as your passport and forms of I.D - **We require to see the originals of these documents.** (Posted originals will be returned the same day received by recorded delivery).
- [ ] Birth Certificate and Driving License
- [ ] HPC or NMC Entry Certificate and up to date renewal card
- [ ] Copy of your most recent DBS – less than 1 year old
- [ ] Training Qualifications – Diploma/Degree/NVQ – Any other training Certificates
- [ ] Mandatory Training Certificates > 1 Year
  - – Manual Handling
  - – Basic Life Support, Paediatrics need Paeds Life support and Midwives New Born Life Support
  - – Data Protection, Complaints Handling, COSHH, Fire, Infection Control, Lone worker, Riddor, Violence and Aggression, Health & Safety, 'Quality, Diversion & Inclusion', Safe Guarding Children & Young People Level 2 minimum (if you need to update these please let us know and we will arrange this for you)
  - – Mental Health Nurses will need Restraint Training
- [ ] Immunisations
  - – Hep B
  - – Varicella
  - – Evidence of BCG – OR completed TB form, or confirmation on Letter Head paper, including your details and the GMC NMC number of the practitioner confirming the scar
  - – Measles
  - – Rubella
- [ ] EPP Candidates (IVS = identification was shown at time of blood test)
  - – Hep B Surface Antigen (IVS)
  - – Hep C (IVS)
  - – HIV (IVS)
- [ ] 2x Passport Size Photos
- [ ] Proof of National Insurance Number

2x Reference forms. Please ask 2 senior members of staff to complete the reference forms and return them to us. This is to speed up your application. If we apply for them ourselves we often struggle to get them returned and it delays the process. We are happy to apply for them if it is not possible for you to get them. Please ensure they include verification. We will contact the referee to varify once they have been received. All references will be verified by a member of the compliance team, via phone or e-mail

To be paid through a Limited Company please ensure you send

- – Certificate of Incorporation
- – Evidence of limited bank details and company name ie bank statement or blank cheque
- – VAT Certificate
- – Signed Self Billing Form (enclosed)

Thank you for completing your registration form

☑ Book an appointment to register in the office, as long as you bring all your documents we will pay your travel

☑ Get yourself compliant within two weeks and we will give you a FREE uniform

☑ We run a daily payroll service.

☑ Do you know if you refer your friends we will pay you £100 per person? Many of our candidates are earning 100's through referrals every month, why not start today?"

Referral 1. Name		Telephone Number	
Referral 2. Name		Telephone Number	
Referral 3. Name		Telephone Number	
Referral 4. Name		Telephone Number	
Referral 5. Name		Telephone Number	

We agree to refund your travel costs to the office, you must provide a receipt, this is on the condition that you bring all the requested documentation with your on the day. You must be fully compliant within two weeks of receiving your registration pack. We will pay you £100 for every nurse you refer, they must complete 100 hours to receive payment and must be new referalls that are not already held in our data base.