Application Form

Healthcare Solutions Services Ltd
Marsh Way, Rainham. RM13 8EU
Tel No: 020 8596 5067
Fax No: 020 8181 6777

Please ensure all sections are completed in BLOCK CAPITALS

Personal Details

Position applied for:

Title: Surname:

Forename: Maiden Name:

Address:

Postcode:

Date From:

Last 5 years of residential address required (Continuation Sheet Provided)

Telephone No: Mobile:

Email: NI Number:

Date of Birth Nationality:

Visa Yes ☐ No ☐

If Yes expiry date:

NMC Pin Number: Expiry Date:

Next of Kin to be notified in case of emergency

Name:

Address:

Postcode:

Telephone No: Mobile:

Bank/Building Society Details

Account Holders Name:

Bank Name: Building Society Roll No:

Account No: Sort Code

I authorise Healthcare Solutions to pay my weekly earnings directly into the bank or building society whose details I have given above. I confirm that I will notify Healthcare Solutions in writing of any changes of these details

Signed: **Date**:

If you require to be paid through a UK Limited or Composite company, then the following details are required. N.B. Certificates of registration will be required.

Company Name: Company Registration No:

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Can you please confirm completion of IR35. Yes ☐ No ☐

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General Information

Do you hold a driving licence? Yes ☐ No Are you a car owner? Yes ☐ No ☐

How far are you willing to travel?

Do you have a current passport? Yes ☐ No ☐ Are you computer literate? Yes ☐ No ☐

Please state which languages you speak, including an indication of fluency

How did you hear about Healthcare Solutions?

Do you belong to a Union? Yes ☐ No ☐

Body Name | Amount of cover:

Policy Number: | Expiry date:

Please complete the section that applies to you.

Section A ☐ Trained Nurses only
Section B ☐ Social Work
Section C ☐ H.C.As, Support Worker, R.S.W, Teaching Assistant
Section D ☐ Physiotherapists, Occupational Therapists
Section E ☐ Doctor

Opt-Out of 48 Hour Working Week Agreement:

1. DEFINITIONS - In this Agreement the following definitions apply:-
"Worker" Agency Member, "Working Week" means an average of 48 hours each week
References to the singular include the plural and references to the masculine include the feminine and vice versa.
The headings contained in this Agreement are for convenience only and do not affect their interpretation.
2. RESTRICTION - The Working Time Regulations 1998 provide that the Worker shall not work in excess of the Working Week unless they agree in writing that their limit should not apply.
3. CONSENT - The Worker hereby agrees that the Working Week limit shall not apply.
4. WITHDRAWAL OF CONSENT - The Worker may end this Agreement by giving 3 months notice in writing.
For the avoidance of doubt, any notice bringing this Agreement to an end shall not be construed as notice of termination by the Worker upon the expiry of the notice period set out in clause 4.1 the Working Week limit shall apply with immediate effect.
5. THE LAW - These terms are governed by English and Scottish law and are subject to the exclusive jurisdiction of the English and Scottish Courts

Signed: **Date:**

Equal opportunities statement for use at the beginning of the form

Healthcare Solutions is committed to a policy of equal opportunities for all work seekers and shall adhere to such a policy at all times and will review on an on-going basis on all aspects of recruitment to avoid unlawful or undesirable discrimination. We will treat everyone equally irrespective sex, sexual orientation, gender reassignment, marital or civil partnership status, age, disability, colour, race, nationality, ethnic or national origin, religion or belief, political beliefs or membership or non-membership of a Trade Union and we place an obligation upon all staff to respect and act in accordance with the policy.

Healthcare Solutions shall not discriminate unlawfully when deciding which candidate/temporary worker is submitted for a vacancy or assignment, or in any terms of employment or terms of engagement for temporary workers. Healthcare Solutions will ensure that each candidate is assessed only in accordance with the candidate's merits, qualification and ability to perform the relevant duties required by the particular vacancy.

Criminal Convictions

Do you have any unspent* criminal convictions? Yes ☐ No ☐

If yes, state convictions and dates

*Certain types of employment and professions are exempt from the Rehabilitation of Offenders Act 1974 and in those cases particularly where the employment is sought in relation to positions involving working with children or vulnerable adults, details for all criminal convictions must be given. The information given will be treated in the strictest of confidence and only taken into account where, in the reasonable opinion of Healthcare Solutions, the offence is relevant to the post to which you are applying. **Failure to declare a conviction may require us to exclude you from our register or terminate an assignment if the offence is not declared but later comes to light.**

I authorise Healthcare Solutions to carry out a DBS check on my behalf as and when required. And also complete regular update service checks and retain a copy of my DBS Certificate.

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Signed: **Date:**

Permission to work in the UK

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

In line with UKBA guidance on the prevention of illegal working we will need to verify and take a copy of your original ID documentation as evidence of your right to work in the UK if you are to be engaged by Healthcare Solutions for temporary work

NMC Registration checks *NURSES/MIDWIVES ONLY.*

Do you authorise Healthcare Solutions to carry out monthly NMC pin checks in order to ensure you remain fit to work? Yes ☐ No ☐

* The role of the NMC is to protect the public by ensuring that nurses, midwives and specialist community public health nurses provide high standards of care. The NMC sets and improves standards for the education, training and conduct of those on the register, and it provides advice and considers allegations of misconduct, lack of competence or unfitness to practise due to ill health.
The Fitness to work monthly check purpose is to safeguard the health and wellbeing of the public by assessing if a nurse or midwife's fitness to work is impaired.

Signed: **Date:**

Health and Disability

The following questions on health and disability are asked in order to find out your needs in terms of reasonable adjustments to access our recruitment service and to find out your needs in order to perform the job or position sought.

Do you have any health issues or a disability relevant which may make it difficult for you to carry out functions which are essential for the role you seek?

Yes ☐ No ☐

If yes, please specify

If you have a disability, what are your needs in terms of reasonable adjustments in order to access this recruitment service and to attend interview, or to take aptitude tests etc?

Please specify

Data Protection Statement

The information that you provide on this form and on any CV given will be used by Healthcare Solutions to provide you work finding services. In providing this service to you, you consent to your personal data being included on a computerised database and consent to us transferring your personal details to our clients.

We may check the information collected, with third parties or with other information held by us.

We may also use or pass to certain third parties information to prevent or detect crime, to protect public funds, or in other way permitted or required by law.

Signed: **Date:**

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Employment History

Please print details of all your employment, to include all nursing agency membership, in reverse date Order, starting with your present or last position for the last ten years. Please include reason for any gaps.

Name & Address of Employer	Position (s) Duties	Date from	Date to	Reason for Leaving

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Training e.g. Manual, First Aid, etc (please provide certificates)

Details of training Course taken	Date From	Date To	Attainment

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Professional References

Name:		Name:	
Position Held By Referee:		Position Held By Referee:	
Department:		Department:	
Address:		Address:	
Telephone:		Telephone:	
Fax:		Fax:	
Email:		Email:	
Name of Organisation:		Name of Organisation:	

Name:		Name:	
Position Held By Referee:		Position Held By Referee:	
Department:		Department:	
Address:		Address:	
Telephone:		Telephone:	
Fax:		Fax:	
Email:		Email:	
Name of Organisation:		Name of Organisation:	

I hereby give Healthcare Solutions permission to approach my referees at this stage for employment references and understand that Healthcare Solutions reserve the rights to withdraw my application if my references do not meet a satisfactory level for healthcare staffing.

Signed: **Date:**

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Preference regarding work

Please specify which types of work you would prefer. You should tick all appropriate boxes. The service we give depends on accurate, up to date information. Please keep us informed of all development, in your career & work preferences.

Position	Part-time	Full-time
Types of work	NHS	Private hospitals
	Nursing Home	Industry
	Clients in their own home	other, please specify:
	Live in	Days
	Nights	Visit

Do you have any other work commitments?

Which areas of work do you wish to exclude?

When will you be available to start work?

Length of time available? *(for overseas nurses only)*

Are you interested, now or in the future, in a permanent post in the UK ☐ Yes ☐ No

Section A – Key Wording for trained Nurses only

SPECIALISM	Less than 6 Months	More than 6 months	1 – 2 Years	2 + Years	SPECIALISM	Less than 6 Months	More than 6 months	1 – 2 Years	2 + Years
A & E	☐	☐	☐	☐	Neurology	☐	☐	☐	☐
Anesthetic Trained	☐	☐	☐	☐	Nursing Home	☐	☐	☐	☐
Ante Natal	☐	☐	☐	☐	Occupational Health	☐	☐	☐	☐
Cardiac	☐	☐	☐	☐	ODA	☐	☐	☐	☐
Cardiothoracic	☐	☐	☐	☐	Oncology	☐	☐	☐	☐
Care of Elderly	☐	☐	☐	☐	Ophthalmology	☐	☐	☐	☐
Chemotherapy	☐	☐	☐	☐	Orthopedics	☐	☐	☐	☐
Community Nursing	☐	☐	☐	☐	Out Patient	☐	☐	☐	☐
Cosmetic Surgery	☐	☐	☐	☐	Pediatric	☐	☐	☐	☐
Day Care Centre	☐	☐	☐	☐	PICU	☐	☐	☐	☐
Day Surgery	☐	☐	☐	☐	Phlebotomy	☐	☐	☐	☐
District Nursing	☐	☐	☐	☐	Practice Nurse	☐	☐	☐	☐
Family Planning	☐	☐	☐	☐	Prison	☐	☐	☐	☐
GU Med	☐	☐	☐	☐	Psychiatric	☐	☐	☐	☐
Gynaecology	☐	☐	☐	☐	Radiology	☐	☐	☐	☐
Haematology	☐	☐	☐	☐	Recovery	☐	☐	☐	☐
Health Visitors	☐	☐	☐	☐	Renal	☐	☐	☐	☐
high dependency unit	☐	☐	☐	☐	Residential	☐	☐	☐	☐
Home Care	☐	☐	☐	☐	SCBU	☐	☐	☐	☐
Hospital	☐	☐	☐	☐	Screening	☐	☐	☐	☐
In Charge Duties	☐	☐	☐	☐	Stoma Care	☐	☐	☐	☐
Intensive Care	☐	☐	☐	☐	Surgical	☐	☐	☐	☐
ITU Psychiatric	☐	☐	☐	☐	Terminal Clinic	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	Theatre	☐	☐	☐	☐
Liver Unit	☐	☐	☐	☐	Tropical Disease	☐	☐	☐	☐
Medical Assess Unit	☐	☐	☐	☐	Urology	☐	☐	☐	☐
Mental Health	☐	☐	☐	☐	Vena Puncture	☐	☐	☐	☐
Midwifery	☐	☐	☐	☐	X-ray	☐	☐	☐	☐
Neonatal	☐	☐	☐	☐					

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Section B – Key Wording for Social Workers ONLY

SPECIALISM	Less than 6 Months	More than 6 months	1 – 2 Years	2 + Years	SPECIALISM	Less than 6 Months	More than 6 months	1 – 2 Years	2 + Years
Adolescent	☐	☐	☐	☐	Hospital Worker	☐	☐	☐	☐
Adult	☐	☐	☐	☐	Learning Disability	☐	☐	☐	☐
Child Protection	☐	☐	☐	☐	Mental Health	☐	☐	☐	☐
Children	☐	☐	☐	☐	Physical Disabled	☐	☐	☐	☐
Drug	☐	☐	☐	☐	Probation Service	☐	☐	☐	☐
Education	☐	☐	☐	☐	Residential	☐	☐	☐	☐
Elderly	☐	☐	☐	☐	Sensory Impairment	☐	☐	☐	☐
Family	☐	☐	☐	☐	Senior Manager	☐	☐	☐	☐
Family Centre	☐	☐	☐	☐	Unqualified Social Worker	☐	☐	☐	☐
HIV	☐	☐	☐	☐	Social Worker Trainer	☐	☐	☐	☐
Homeless	☐	☐	☐	☐	OTHER	☐	☐	☐	☐

Section C – Key Wording for Care Assistants/RSW's ONLY

Please tick any certificates that you hold.

Aggression Awareness	☐	Break Away	☐	C & R	☐	CPR	☐
Food Hygiene	☐	First Aid	☐	Health & Safety	☐	House Keeping	☐
Medication Certificate	☐	Moving & Handling	☐	NVQ 1,2,3,4			

Any other please state:

Please tick keywords which you have experience in:

SPECIALISM	Less than 6 Months	More than 6 months	1 – 2 Years	2 + Years	SPECIALISM	Less than 6 Months	More than 6 months	1 – 2 Years	2 + Years
Autism	☐	☐	☐	☐	NVQ	☐	☐	☐	☐
Catheter Care	☐	☐	☐	☐	Observation BP	☐	☐	☐	☐
Fluid Chart	☐	☐	☐	☐	Observation	☐	☐	☐	☐
Home Care	☐	☐	☐	☐	Private Home	☐	☐	☐	☐
Hospitals	☐	☐	☐	☐	Pediatrics	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	Residential Homes	☐	☐	☐	☐
Mental Health	☐	☐	☐	☐	Senor	☐	☐	☐	☐
Nursing Homes	☐	☐	☐	☐	Schools	☐	☐	☐	☐
NNEB	☐	☐	☐	☐	Urinalysis	☐	☐	☐	☐

Section D – Key Wording for Chefs, Cooks, Domestic and Porting Staff

Health & Safety at Work	☐	City & Guide in Cleaning	☐	Food Hygiene	☐	Moving & Handling	☐
BTEC in Catering/Hotel Mgmt	☐	High National Diploma	in	Catering/Hotel Management	☐	COSHH	☐
NVQ in Catering	☐						

Any other please state

Occupational Health Assessment

General Health Questions	Yes	No	Details
Are you in good health?	☐	☐	
How much time have you lost from work due to illness or surgery in the past five years? (Please give details)	☐	☐	
Have you ever been treated in hospital for serious illness or surgery? (Please give dates)	☐	☐	
Have you been treated in hospital during the last 12 months	☐	☐	
Do you have any physical disabilities that could affect your Ability to carry out your assignment?	☐	☐	
Have you ever left, been retired or denied a job on health grounds	☐	☐	
Have you ever been denied a driving licence on health grounds?	☐	☐	
Are you a registered disabled person?	☐	☐	
Have you any disability related to your physical or mental health	☐	☐	
Have you ever suffered from mental illness, psychological or Psychiatric problem?	☐	☐	
Do you get discomfort or pain in the chest or shortness of breath on Exercise?	☐	☐	
Have you ever had any problems with your joints, including pain, Swelling or stiffness?	☐	☐	

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Do you need to wear glasses or contact lenses?	☐	☐	
Do you have any difficulty with your eyesight which is not corrected by Glasses or contact lenses?	☐	☐	
Have you any problems working with Visual Display Units?	☐	☐	
Have you any problems working in confined spaces/using lifts?	☐	☐	
Do you have any difficulty hearing normal conversation?	☐	☐	
Are you taking any medication that makes you dizzy or drowsy?	☐	☐	
Do you have a medical condition affected by changing sleeping patterns Or affecting day time sleep?	☐	☐	
Have you suffered from any alcohol or drug related illness or had an Alcohol or drug problem?	☐	☐	
Are you having or awaiting any treatment at the moment?	☐	☐	
What is the date of your last x-ray?	☐	☐	
Are you receiving Medicines, Pills, or Tablets from a doctor or on Prescription?	☐	☐	
Have you ever suffered from any of the following?			
Heart Problems/Circulatory Illness/Hypertension	☐	☐	
High or Low Blood Pressure	☐	☐	
Diabetes	☐	☐	
Asthma/Hay fever	☐	☐	
Bronchitis/Pneumonia/Pleurisy	☐	☐	
Tuberculosis	☐	☐	
Epilepsy/Fainting Attacks/Blackouts/Fits/Sudden Collapse	☐	☐	
Headaches/Migraine	☐	☐	
Psychiatric Illness/Anxiety/Depression	☐	☐	
Dermatitis/Skin Sensitivity/Psoriasis/Eczema/Allergies	☐	☐	
Back injury/Back Problems/Back Pains	☐	☐	
Recurrent Infections e.g. Sore Throats/Ear Infections/Eye Infections	☐	☐	
Hepatitis/Jaundice	☐	☐	
Have you ever been tested or inoculated for any of the following?			
Varicella	☐	☐	
Tuberculosis including BCG	☐	☐	
Health, x-ray, Blood Test	☐	☐	
Rubella (German Measles)	☐	☐	
Poliomyelitis	☐	☐	
Hepatitis A	☐	☐	
Hepatitis B	☐	☐	
Hepatitis C	☐	☐	
HIV	☐	☐	
Tetanus, Polio, Diphtheria	☐	☐	
Typhoid	☐	☐	
Do you smoke	☐	☐	
Any Other	☐	☐	
Please Enter your Height & Weight	Height:	Weight:	

I declare the statements are true and complete to the best of my knowledge and belief. I understand that my General Practitioner may be consulted with my prior consent.

Signed: **Date**:

Third Party Declaration:

I hereby consent to allow any information relating to my registration with Healthcare Solutions to be shared with relevant third parties.

This will be overseen by the governance lead for Healthcare Solutions.

Signed: **Date:**

Declaration:

I hereby confirm that the information given is true and correct. I consent to my personal data and CV being forwarded to clients. I consent to references being passed onto potential employers.

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If, during the course of a temporary assignment, the Client wishes to employ me direct, I acknowledge that Healthcare Solutions will be entitled either to charge the client an introduction/transfer fee, or to agree an extension of the hiring period with the Client (after which I may be employed by the Client without further charge being applicable to the Client).

Signed: **Date:**

Healthcare Solutions aims to be an equal opportunities provider of work and we select solely on merit irrespective of race, sex, disability etc.

You must provide all other addresses where you have lived in the last 5 years. There must be no gaps in dates

Address Continuation Sheet

Address:

Town/City:

County:

Post Code: Country:

Dates from and to:

You must provide all other addresses where you have lived in the last 5 years. There must be no gaps in dates

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Address:

Town/City:

County:

Post Code: Country:

Dates from and to:

You must provide all other addresses where you have lived in the last 5 years. There must be no gaps in dates

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You must provide all other addresses where you have lived in the last 5 years. There must be no gaps in dates

Address Continuation Sheet

Address:

Town/City:

County:

Post Code: Country:

Dates from and to: