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|  | | | | | Goshen Health  74 Crosshands Road, Gorslas  Carmarthenshire, Wales, SA14 6RH  **Tel:** 01269 540 629 | 07411 883 673  **Email:** info@goshen-health.uk  **Website:** www.goshen-health.uk | | | |
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| CANDIDATE REGISTRATION FORM PERSONAL DETAILS | | | | | | | | |
| Please write in BLOCK CAPITALS and in black ink. | | | | | | | | |
| ABOUT YOU | | | | | | | | |
| Surname: | |  | | Title (Mr/Mrs/Miss/Ms) : | | |  | |
| First Name(s) : | |  | | Other Name(s): | | |  | |
| Marital Status: |  | | Gender: | Male Female | | Date of Birth: | |  |
| National Insurance No: | |  | |  | | |  | |
| Current Address: | |  | | | | | | |
| Post Code: | |  | | | | | | |
| Mobile Phone: | |  | | Home Phone: | | |  | |
| Do you have a driving licence? | | Yes No | | Do you have use of a car? | | | Yes No | |

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| ABOUT THE JOB | | | | | |
| Job Title: |  |  |  |  |  |
| Speciality 1: |  | Speciality 2: |  | Speciality 3: |  |
| Current Place of Work: |  | | Full Time Part Time  Days Nights | | |

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| PAYMENT DETAILS | | | | |
| Name of Bank/Building Society: |  |  |  |  |
| Account Name: |  | | Personal LTD | |
| Branch Address: |  | | | |
| Post Code: |  | | | |
| Account No: |  | | Sort Code: |  |

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| NEXT OF KIN | | | |
| Name of Next of Kin: |  | Relationship: |  |
| Telephone: |  |  |  |
| Address |  | | |

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| 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: | | |  | This does not apply to HCA’s | | | | | | | | |
|  | | | | | | | | | | | | | |
| 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: | |  | Food Hygiene (where  required to handle food): | | |  | Personal Safety (Mental  Health &Learning Dis’): | |  | Resuscitation of the  Newborn (Midwifery): | | |  |
| Interpretation of Cardiotocograph Traces (Midwifery): | | | | | |  |  | | | | | | |

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| 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: |  | |

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| 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. Reference Name: |  | Position: |  |
| Work Address: |  | | |
| Postcode: |  | | |
| Email: |  | | |
| Telephone: |  | Fax: |  |
|  | | | |
| 2. Reference Name: |  | Position: |  |
| Work Address: |  | | |
| Postcode: |  | | |
| Email: |  | | |
| Telephone: |  | Fax: |  |

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| YOUR TRAINING, QUALIFICATIONS, APPRAISALS AND REFERENCES | | | |
| **Please enclose, with your application a copy of your registration and membership card** | | | |
| 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 |  |
| *You will be requested to carry out a DBS at registration and annually upon employment* | | | |

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| IMMUNISATIONS | | | | | | | | |
| Please indicate which off the following Immunisations you have been vaccinated against and include your vaccination reports when returning your registration. | | | | | | | | |
| EPP and Non EPP | **Hep B**  Yes  No | | **TB**  Yes  No | **Varicella**  Yes  No | | **Measles**  Yes  No | | **Rubella**  Yes  No |
| EPP Candidates Only | **Hep C**  No Proof  Negative  Positive | | **Hep B Antigen**  No Proof  Negative  Positive | | | **HIV**  No Proof  Negative  Positive | | |
| All applications who cannot provide a registered DBS or full immunisation record will be required to complete at their own cost. Goshen Health 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 sign to say you have read and understood the above | | | | | | | | |
| Your Signature: | |  | | | Date: | |  | |

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| WORK HISTORY | | | | | |
| **Please ensure you complete this section even if you have a CV. The NHS states that “Employment history should be recorded on an Application Form which is signed” Please ensure that you leave no gaps unaccounted for and it covers 10 years or up to your education.** | | | | | |
| Covers 10 years work history or as far back as 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: |  | Name of Employer: |  |
| Job Title: | |  | | Grade: |  |
| Address: | |  | | Main Responsibilities: |  |
| Reason for Leaving: | |  | | | |

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| From: |  | To: |  | Name of Employer: |  |
| Job Title: | |  | | Grade: |  |
| Address: | |  | | Main Responsibilities: |  |
| Reason for Leaving: | |  | | | |

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| From: |  | To: |  | Name of Employer: |  |
| Job Title: | |  | | Grade: |  |
| Address: | |  | | Main Responsibilities: |  |
| Reason for Leaving: | |  | | | |

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| From: |  | To: |  | Name of Employer: |  |
| Job Title: | |  | | Grade: |  |
| Address: | |  | | Main Responsibilities: |  |
| Reason for Leaving: | |  | | | |

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| DECLARATIONS | | | | | |
| HEALTH DECLARATIONS | | | | | |
| 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 Goshen Health /Care Providers Recruitment to release your information for inspection.  I …………………………………………………………………………………………………………………. consent to Goshen Health /Care Providers Recruitment releasing my health and immunisation records for review to Goshen Health 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 Goshen Health /Care Providers 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 Goshen Health /Care Providers Recruitment should my general condition of health change.  I will inform Goshen Health /Care Providers 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 Goshen Health /Care Providers Recruitment obtaining further information regarding my health from my GP or Occupational Health Department. | | | | | |
| Signed: |  | Print Name: |  | Date: |  |

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| PERSONAL DECLARATIONS | | | | | |
| 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 endeavours 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. | | | | | |
| Signed: |  | Print Name: |  | Date: |  |

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| WORKING TIME REGULATIONS DECLARATIONS | | | | | |
| 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 Goshen Health /Care Providers Recruitment not less than three months’ notice at any time. | | | | | |
| Signed: |  | Print Name: |  | Date: |  |

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| OTHER DECLARATIONS | | | | | |
| 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: |  |

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| 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 (Goshen Health /Care Providers 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 (Goshen Health) under the Terms of Engagement. | | | | | |
| Signed: |  | Print Name: |  | Date: |  |

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| 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 bindovers?   If yes please give details... | | | | | Yes No |
| 1. Have you ever had disciplinary action taken against you?   If yes please give details... | | | | | Yes No |
| 1. Are you at present the subject of criminal charges or disciplinary action?   If yes please give details... | | | | | Yes No |
| 1. Do you consent to Goshen Health requesting a police check and any appropriate references on your behalf? | | | | | Yes No |
| 1. Have you been police checked in the last three years?   If so, by whom... | | | | | Yes No |
| Signed: |  | Print Name: |  | Date: |  |

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| 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: |  |

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| 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 staff that an individual is in trouble, Fire Policy and the Violent Episode Policy. | | | | | |
| Signed: |  | Print Name: |  | Date: |  |

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| REGISTRATION FORM DECLARATIONSPlease read before signing | | | | | |
| I declare that by signing this form 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 Goshen Health /Care Providers Recruitment 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 1998.  In addition, I confirm that that all the information provided is true and accurate and that I have received and agree to Goshen Health / Care Providers Recruitment terms of engagement and Staff Handbook. | | | | | |
| Signed: |  | Print Name: |  | Date: |  |

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| Please send your completed registration pack to: |
| 74 Crosshands Road, Gorslas, Carmarthenshire, Wales, SA14 6RH |



## NEW EMPLOYEE CLINICAL 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 Healthier Business UK Ltd and may need to be seen by an occupational health advisor or physician. Your record will be held on file for a short period of time and may be subject to audit. Your file may also be used to cross reference and ascertain your fitness should you register with other clients of Healthier Business UK Ltd.

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| --- | --- | --- | --- | --- | --- | --- |
| **Personal Information** | | | | | | |
| Title | Surname | | First names | | | DOB |
|  |  | |  | | |  |
| Home Tel: | | Work Tel: | | | Mobile: | |
| Home Address: | | | | GP Address: | | |

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| **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? |  |  |

If you have indicated yes to any of the above questions you must provide further details in additional information section, failure to do so will result in the form being **returned/rejected**.

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| **Additional Information**  **(If you have answered yes to any questions above please provide additional information below)** |
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| **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 year (**Include Holidays/ Vacations**) | |  |  |
| **If you answered NO to the above, please list all of the countries that you have lived in/visited over the last year, including holidays and vacations. This MUST include duration of stay and dates or this form will be rejected.** | | | |
| Have you had a BCG vaccination in relation to Tuberculosis? | |  |  |
| If you answered yes please state when | Date |  | |

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| **Tuberculosis Continued** |  |  |
| Do you have any of the following | Yes | No |
| 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 |  |  |

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| **EVD (Ebola Virus Disease)** |  | |
| Any person who has been in West Africa in the previous 21 days or those wishing to visit the affected areas must ensure that those deemed the employer are made aware prior to travel and return.  You will be provided with a separate Ebola Screening Questionnaire to complete as applicable. | Yes | No |
| Have you travelled to any countries affected by Ebola? (Guinea, Sierra Leone, Liberia or Mali) |  |  |
| **If you answered YES to the above, please list all of the countries that you have lived in/visited in the last 21 days including holidays and vacations. This MUST include duration of stay and dates or this form will be rejected.** | | |

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| **Additional Information**  **(If you have answered yes to any questions above please provide additional information below)** |
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| **Chicken Pox or Shingles** | | |
| Have you ever had chicken pox or shingles | | |
| **Yes** | **No** | **Date** |
|  |  |  |

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| **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 |  | | |
| Boosters: | 1 |  | 2 |  | 3 |  | | |

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| **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 and Measles |
| **Hepatitis B** | You must provide a copy of the most recent pathology report showing titre levels of 100lu/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 sample. (IVS) |

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| **Exposure Prone Procedures** | | |
| Will your role involve Exposure Prone Procedures | Yes | No |

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| **Declaration** | | |
| I will inform my employer if I am planning to or leave the UK for longer than a three month period to enable a reassessment of my health to be conducted on my return.  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. | | |
| **Name** | **Signature** | **Date** |
|  |  |  |

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| |  | | --- | | 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 Right to work in the UK as well as your passport, we need a copy of the photo page and the outside of the passport.  Birth Certificate and Driving Licence  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, Loneworker, Riddor, Violence and Aggression, Health & Safety, 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 verify 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) |