

**Application Form**

Prior to completing this form, you must telephone the Criminal Records Bureau 0870 909 0822 to apply or an Enhanced Disclosure. This will cost around £33.00. Please quote Medical Station 24.

Please complete this form and bring it to our offices. The Registration office opening times are 8am to 5pm Monday to Friday. Please call the office to make an appointment. If you wish to register in a particular area of the country and are not local to us, we may be able to arrange a meeting and register you at a place convenient to yourself. An application and other information can be downloaded from our website.

**www.medical-station.co.uk or call**

**Tel:**

**24 hours a day, 7 days a week, 365 days a year**

**Trained nurses will need the following in order to register:**

1. Enhanced Disclosure
2. Passport and work permit (if applicable)
3. Two passport photos
4. Statement of entry or pin card
5. Two references, email address telephone numbers and fax numbers of two previous employers
6. Certificates of CPR and Manual Handling dated within the last 12 months
7. Immunisation detail and test results of Hepatitis B immunisation - or details of where we can obtain this information.

When registering please bring with you any other certificates or qualifications that you may have obtained. if you have an up to date CV/resume please bring this with you.

**Healthcare Assistants will need the following to register:**

1. Enhanced Disclosure
2. Passport and work permit (if applicable)
3. Two Passport photos
4. Two references, email address telephone numbers and fax numbers of two previous employers

If you have any certificates of training, Manual Handling/CPR, NVQ’s, Control and Restraint, Food and Hygiene and a CV/Resume or any other certificates relevant to this industry please bring them with you upon registration.

It is a requirement of the agency that you’re able to read speak and understand the English Language.

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Branch: | |
| Position applied for: |  |  |  |
| Name in full: |  | Title: | |
|  | |  | |
| Address in full: | |  | |
| Postcode: |  |  |  |
| Landline: |  | Work: | |
| Mobile: |  | Email: | |
| Date of birth: |  | Place of Birth: | |
| Marital Status: |  | Maiden name: | |
| Nationality: |  | CRB reference: | |
| How did you hear of Medical Station 24: |  |  |  |

Do you require a work permit? If yes, expiry details:

Are you prepared to accept early morning calls or late at night?

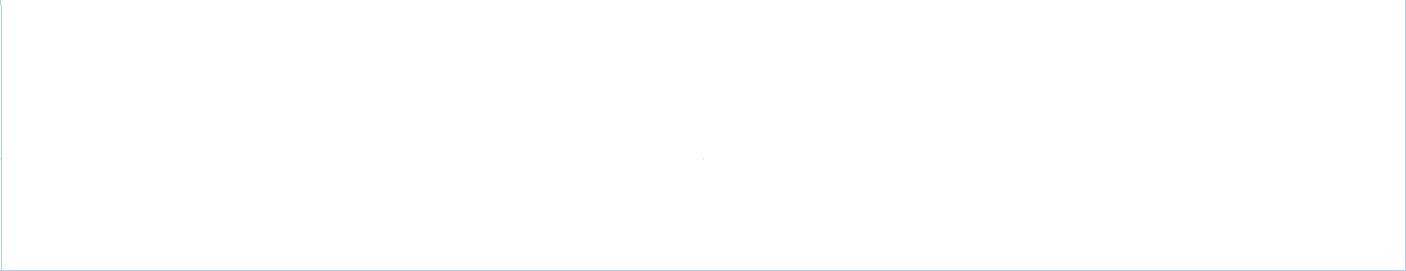
How far are you prepared to travel?

If you are shortlisted you will be asked to produce 'specified0documents' (e.g. a P60, UK birth0certificate, passport,

Work permit) confirming your right to live and work in the UK in accordance with the Asylum and immigration Act 1996 section 8

Would you be able to produce such a document?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | PAYROLL INFORMATION REQUIRED:**!** |  |  |  | **!** |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Surname: | | First Name: | **!** |  |  | Title: |  |
| Address: | |  |  |  |  |  |  |
|  | |  |  |  |  |  |  |
| Contact telephone numbers: | |  |  |  |  |  |  |
| Date of birth: | |  |  | NI Number: | | |  |

Qualifications:

Nursing – RNLD RNSL RGN RSCN RFN RM RMN ENMH RNMH

Other – CARER SUPPORT WORKER HCA OTHER

NEXT OF KIN:



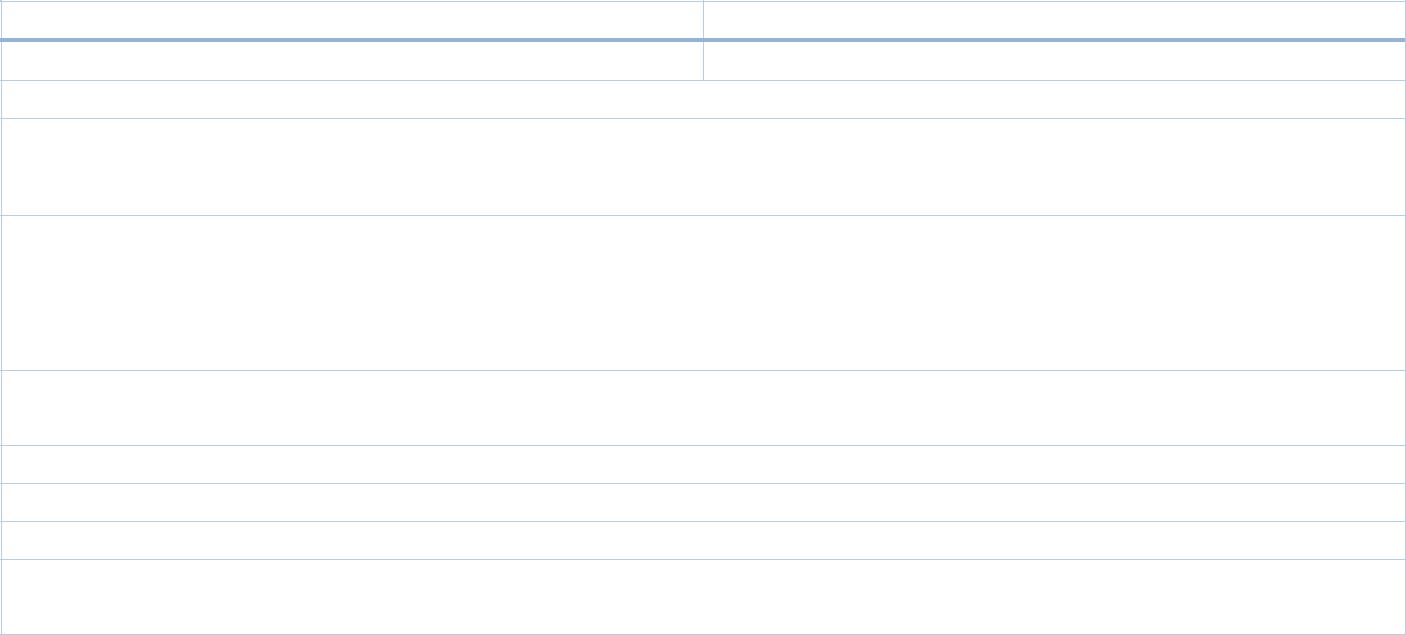
|  |  |
| --- | --- |
| Name: | Relationship: |
| Address: |  |
| Postcode: |  |
| Telephone: |  |



BANK/BUILDING0SOCIETY0DETAILS:**!**



Building Society roll number: Bank name:



Sort code: Account No:

Account holders name:

I authorize Medical Station Ltd to pay my weekly earnings directly into the bank or building society whose details I have given above. I

Confirm I will notify Medical Station in writing of any changes to these details.

Signed: Date:

I have read and understood the Medical Station OPT OUT OF 48 HOUR WORKING WEEK AGREEMENT as described in Rule 72 of the policy and procedures found at [www.medicalstation24.co.uk](http://www.medicalstation24.co.uk) and I hereby consent that the working week limit shall not apply to my assignments in accordance with paragraph 3 of the agreement. I understand that under paragraph 4, WITHDRAWAL OF CONSENT, I can end this agreement by giving the Employment Business 14 day’s-notice in writing.

Print Name: Signed: Date:

If you require to be paid through a UK limited company, please inform your consultant and the below details are required.

Company name:

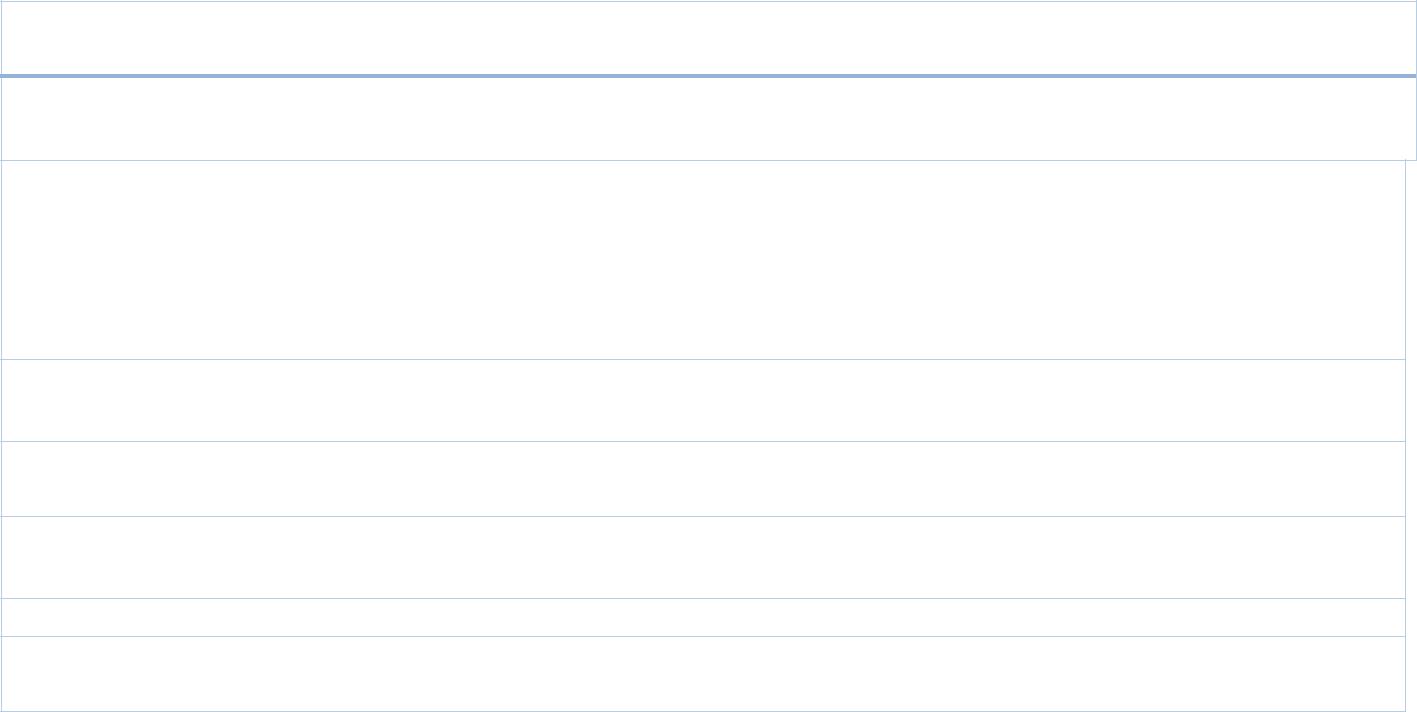
Company Registration no:

Company VAT no: (if VAT payments required)

FOR OFFICE USE: Date set up:

Registration use checked by: Signature:

**REHABILITATION OF OFFENDERS ACT:** Because of the nature of the work for which you are applying, this post is exempt from theprovisions of section 4.2 of the Rehabilitation of Offenders Act 1974 (Exemption order 1975). Applicants are therefore, not entitled to withhold information about convictions which for other purposes are spent under the provisions of the Act and in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action. Any information given will be completely confidential and will be considered only in relation to an application for positions in which the order applies and should be entered at the end of any particulars in support of your application. A copy of our written policies is available upon request. A criminal record will not necessarily be a bar to obtaining a position. PLEASE PROVIDE ADDITIONAL INFORMATION WHICH YOU THINK MAY BE RELEVANT IN SUPPORT OF YOUR APPLICATION.



Have you ever been convicted of a criminal offense? (NB. The Rehabilitation of Offenders Act) if yes, give details below

You may be offered an opportunity to work within an Environment or establishment where you come into contact with

Children or other vulnerable groups, or your professional occupation may fall within certain expected categories where this

Is likely to apply, the Rehabilitation of Offenders Act 1974 (exceptions) order 1975 requires us to ask you for additional

information. A criminal check from the Criminal Records Bureau may be required when this type of work is sought. Do you

have any Criminal convictions, whether or not they are 'spent' within the Act, including any cautions, reprimands, final warnings, or any convictions from overseas Yes No

if yes, give details below

Do you hold a criminal record bureau disclosure or overseas police check carried out within the last 30years?

Yes No

if yes, give details below

Do you hold any form of current Security Clearance? Yes No

If yes, give details below

Date granted: / / Level of Clearance:

Expiry0Date: / / Place of work when granted:

**PROFESSIONAL REFERENCES:**



Medical Station requires clinical references from your last or most recent employer. By professional we mean employers not colleagues, therefore employment addresses are essential.

I declare the references are true and accurate to the best of my knowledge and belief. I consent that my references may be consulted.

**Signed: Date:**

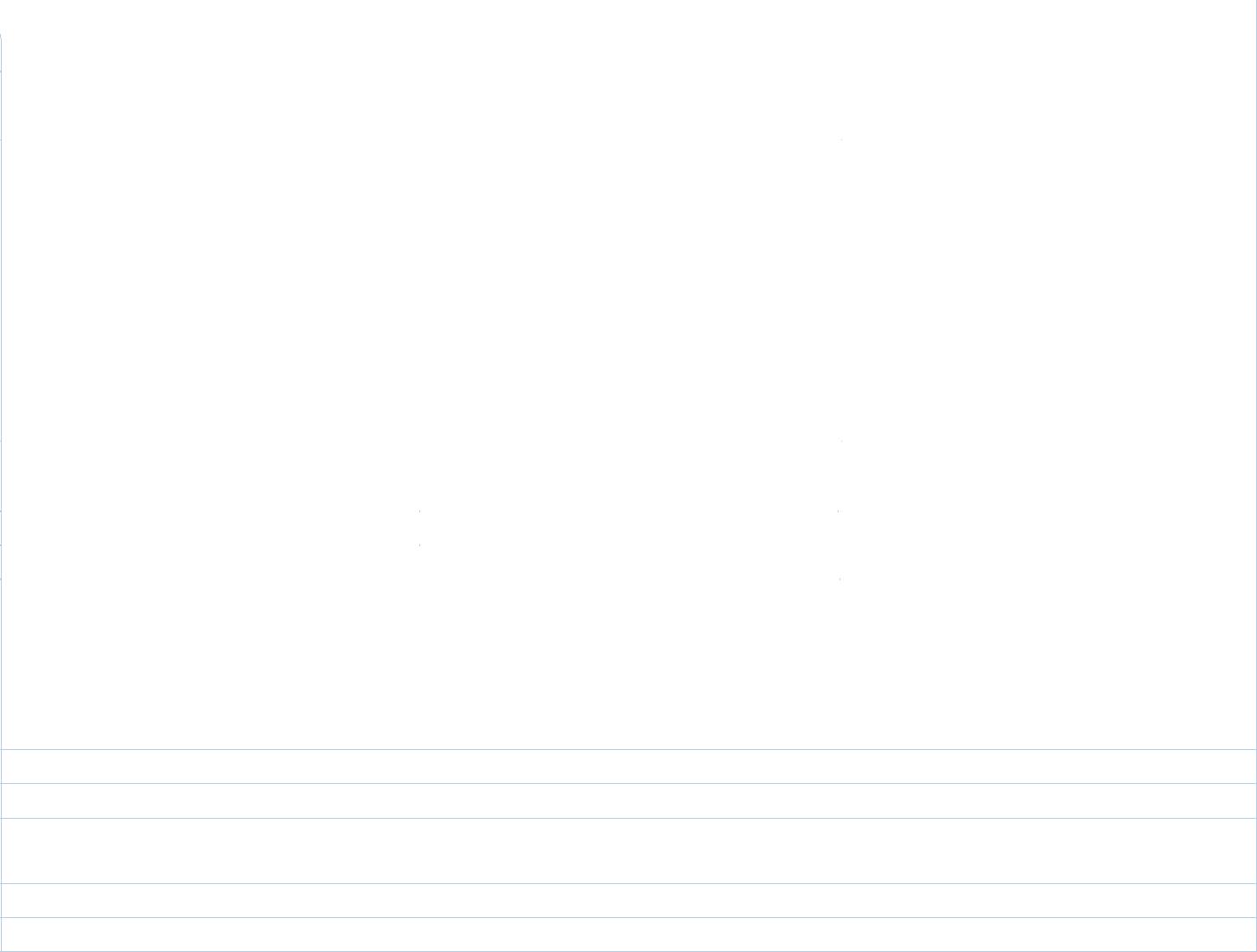
|  |  |
| --- | --- |
| Name: | Name: |
| Position held: | Position held: |
| Department: | Department: |
| Address: | Address: |
|  |  |
| Telephone: | Telephone: |
| Bleep No/ext. | Bleep No/ext. |
|  |  |
| Fax: | Fax: |
| Email: | Email: |
| Name of organisation: | Name of organisation: |
|  |  |



**EMPLOYMENT HISTORY:**



Please give details of employment history during the past 100 years, most recent first. (All gaps must be accounted for – please continue on a blank sheet if necessary



|  |  |  |  |
| --- | --- | --- | --- |
| From: | To: | Employer: | |
| Title of post: |  | Grade: |  |
| Full or Part time: |  | Salary: | |
| Main responsibilities: |  | Dept/Ward: | |
| Reason for leaving: |  |  |  |
|  |  |  |  |
| From: | To: | Employer: | |
| Title of post: |  | Grade: | |
|  |  |  | |
| Full or Part time: |  | Salary: | |
|  |  |  | |
| Main responsibilities: |  | Dept/ward: | |
|  |  |  |  |
| Reason for Leaving: |  |  |  |
|  |  |  |  |
| From: | To: | Employer: | |
| Title of post: |  | Grade: | |
| Full or Part time: |  | Salary: | |
|  |  |  | |
| Main responsibilities: |  | Dept/ward: | |
| Reason for Leaving: |  |  |  |

Have you ever been dismissed from any employment? Yes No

When would you be available for interview:

Do you have any holiday commitments in the next 120months? Yes No

if yes, please give details

Do you have any parental leave commitments? Yes No if yes, please give details

Do you know anyone in our employment? Yes No if yes, please provide names

KEYWORDING FOR TRAINED NURSES ONLY:



Please tick the areas that best describe your work experience. Please note you will be held professionally accountable.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Specialism** |  | **Under 6** |  | **6 +** |  |  | **1F2** |  |  | **2 +** |  | **Specialism** |  | **Under 6** |  |  | **6 +** |  |  | **1 +** |  | **2 +** |  |  |
|  |  |  | **months** |  | **months** |  |  | **years** |  |  | **years** |  |  |  | **months** |  |  | **months** |  |  | **Years** |  | **years** |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| A&E | | |  |  | |  |  | |  |  | |  | MAU |  | |  |  | |  |  | |  | |  |  |
| Anaesthetic | | |  |  | |  |  | |  |  | |  | Mental Health |  | |  |  | |  |  | |  | |  |  |
| Antenatal | | |  |  | |  |  | |  |  | |  | Midwifery |  | |  |  | |  |  | |  | |  |  |
| Cardiac | | |  |  | |  |  | |  |  | |  | Neonatal |  | |  |  | |  |  | |  | |  |  |
| Cardiothoracic | | |  |  | |  |  | |  |  | |  | Neurology |  | |  |  | |  |  | |  | |  |  |
| Care of the elderly | | |  |  | |  |  | |  |  | |  | Nursing homes |  | |  |  | |  |  | |  | |  |  |
| Chemotherapy | | |  |  | |  |  | |  |  | |  | Occupational |  | |  |  | |  |  | |  | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  | Health |  |  |  |  |  |  |  |  |  |  |  |  |
| Community0nursing | | |  |  | |  |  | |  |  | |  | DDO/ODA |  | |  |  | |  |  | |  | |  |  |
| Cosmetic0surgery | | |  |  | |  |  | |  |  | |  | Oncology |  | |  |  | |  |  | |  | |  |  |
| CSSD | | |  |  | |  |  | |  |  | |  | Ophthalmology |  | |  |  | |  |  | |  | |  |  |
| Day0care0center | | |  |  | |  |  | |  |  | |  | Orthopedics |  | |  |  | |  |  | |  | |  |  |
| Day0Surgery | | |  |  | |  |  | |  |  | |  | Outpatients |  | |  |  | |  |  | |  | |  |  |
| Dental | | |  |  | |  |  | |  |  | |  | Pediatric |  | |  |  | |  |  | |  | |  |  |
| District0Nursing | | |  |  | |  |  | |  |  | |  | PICU |  | |  |  | |  |  | |  | |  |  |
| Family0Planning | | |  |  | |  |  | |  |  | |  | Practice Nurse |  | |  |  | |  |  | |  | |  |  |
| GU Med | | |  |  | |  |  | |  |  | |  | Prisons |  | |  |  | |  |  | |  | |  |  |
| Gynecology | | |  |  | |  |  | |  |  | |  | Radiology |  | |  |  | |  |  | |  | |  |  |
| Hematology | | |  |  | |  |  | |  |  | |  | Recovery |  | |  |  | |  |  | |  | |  |  |
| Health0Visitors | | |  |  | |  |  | |  |  | |  | Renal |  | |  |  | |  |  | |  | |  |  |
| HDU | | |  |  | |  |  | |  |  | |  | Residential homes |  | |  |  | |  |  | |  | |  |  |
| Home care | | |  |  | |  |  | |  |  | |  | SCBU |  | |  |  | |  |  | |  | |  |  |
| Hospices | | |  |  | |  |  | |  |  | |  | School Nurse |  | |  |  | |  |  | |  | |  |  |
| Hospitals | | |  |  | |  |  | |  |  | |  | Scrub |  | |  |  | |  |  | |  | |  |  |
| In Charge Duties | | |  |  | |  |  | |  |  | |  | Stoma care |  | |  |  | |  |  | |  | |  |  |
| Intensive Care Unit | | |  |  | |  |  | |  |  | |  | Surgical |  | |  |  | |  |  | |  | |  |  |
| ITU Psychiatric | | |  |  | |  |  | |  |  | |  | Termination Clinic |  | |  |  | |  |  | |  | |  |  |
| Learning Disability | | |  |  | |  |  | |  |  | |  | Theatre |  | |  |  | |  |  | |  | |  |  |
| Medical | | |  |  | |  |  | |  |  | |  | Urology |  | |  |  | |  |  | |  | |  |  |
|  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |



KEYWORDING FOR CARE ASSISTANTS/ HCA's



Please tick any certificates that you hold

Health and Safety at work First Aid Food Hygiene Catering Moving and Handling C&R CPR NVQ 1,2,3,4

Any other please state:

Please state whether you have achieved or are working towards NVQ2:

Please tick keywords with which you have experience:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Specialism** |  |  | **Under 6** |  | **6 +** |  |  |  | **1 +** |  |  | **2 +** | |  |  | **Specialism** | |  | **Under 6** |  |  | **6 +** |  |  | **1 +** |  | **2 +** |  |  |  |
|  |  |  |  | **months** |  | **months** |  |  |  | **years** |  |  | **years** | |  |  |  |  |  | **months** |  |  | **months** | **!** |  | **Years** |  | **years** |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Nursing Homes | | |  |  |  | |  |  |  | |  |  |  |  |  |  | Home care | |  | |  |  | |  |  | |  | |  |  |  |
| Residential Homes | | |  |  |  | |  |  |  | |  |  |  |  |  |  | Senior Care | |  | |  |  | |  |  | |  | |  |  |  |
| Private Homes | | |  |  |  | |  |  |  | |  |  |  |  |  |  | Catheter care | |  | |  |  | |  |  | |  | |  |  |  |
| Hospitals | | |  |  |  | |  |  |  | |  |  |  |  |  |  | Fluid charts | |  | |  |  | |  |  | |  | |  |  |  |
| Schools | | |  |  |  | |  |  |  | |  |  |  |  |  |  | Urinalysis | |  | |  |  | |  |  | |  | |  |  |  |
| Learning Disability | | |  |  |  | |  |  |  | |  |  |  |  |  |  | NVQ |  |  | |  |  | |  |  | |  | |  |  |  |
| Mental Health | | |  |  |  | |  |  |  | |  |  |  |  |  |  | Observations BP | |  | |  |  | |  |  | |  | |  |  |  |
| Paediatrics | | |  |  |  | |  |  |  | |  |  |  |  |  |  | Observations | |  | |  |  | |  |  | |  | |  |  |  |
|  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | OCCUPATIONAL HEALTH ASSESSMENT: | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | General Health Questions | | | |  |  |  |  |  |  |  |  |  | Yes | |  | No | Details**!** | | | |  |  |  |  |  |  |  |  |  |  |
| Are you in good health? | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| How much time have you lost in the last five years | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Due to ill health in the last 50years? Please provide | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| details | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Have you ever been treated in hospital for serious | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Illness or surgery? Please give details | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Have you been treated in Hospital in the last 12 | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| months? | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Do you have any physical disabilities that could affect | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Your ability to carry out this assignment? | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Have you ever left, been retired or denied a job 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 any mental illness, | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Psychological or psychiatric problems? | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Have you ever had any problems with your joints, | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Including pain, swelling of stiffness?**!** | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Would you have difficulty looking over either | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| shoulder? | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Do you need to wear glasses or contact lenses? | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Do you have any difficulty with your eyesight which is | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Not corrected by wearing 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 | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Drowsy or dizzy? | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 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 last date of your chest X-ray? | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Are you receiving medicines, pills, or tablets from a |  |  |  |  |
|  | Doctor or0on0prescription? |  |  |  |  |
|  | Have you ever suffered from any of the following? | Yes | No | Details |  |
|  | Heart problems/Circulatory illness/Hypertension |  |  |  |  |
|  | High or low blood pressure |  |  |  |  |
|  | Diabetes |  |  |  |  |
|  | Asthma/Hay0fever |  |  |  |  |
|  | Bronchitis/Pneumonia |  |  |  |  |
|  | Tuberculosis |  |  |  |  |
|  | Epilepsy/Fainting Attacks/Blackouts/Fits/Sudden |  |  |  |  |
|  | collapse |  |  |  |  |
|  | Headaches/Migraine |  |  |  |  |
|  | Depression/Anxiety |  |  |  |  |
|  | Skin sensitivity/Eczema/Allergies |  |  |  |  |
|  | Back problem/back pains |  |  |  |  |
|  | Recurrent infections Sore Throats/ Ear infections/ |  |  |  |  |
|  | Eye infections |  |  |  |  |
|  | Hepatitis/Jaundice |  |  |  |  |
|  | Have you ever been tested or inoculated for any of | Yes | No | Details |  |
|  | The following? |  |  |  |  |
|  | Varicella |  |  |  |  |
|  | Tuberculosis including BCG |  |  |  |  |
|  | Heave Manteaux or tine |  |  |  |  |
|  | Rubella |  |  |  |  |
|  | Poliomyelitis |  |  |  |  |
|  | Hepatitis A |  |  |  |  |
|  | Hepatitis B |  |  |  |  |
|  | Hepatitis B Antibodies date and Result |  |  |  |  |
|  | HIV |  |  |  |  |
|  | Tetanus |  |  |  |  |
|  | Typhoid |  |  |  |  |
|  | Any other |  |  |  |  |
|  | |  |  |  |  |

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

**Signed: Date:**

DECLARATION:



I declare that the information given in this application form is true to the best of my knowledge and belief. I have read and understood the

Terms of Engagement booklet given to me. I agree to comply with the current Health and Safety at work Act. I understand that my

Appointment is subject to the receipt of a minimum of two satisfactory references and is subject to Enhanced Disclosure. I authorize Medical Station to make any other enquiries they may feel necessary to support my application. I agree to respect the confidentiality of patients and clients and any other information I may have access to at all times. I understand I can access the policies and PAPER BASED COPIES ARE AVAILABLE ON REQUEST.

**Signed: Date:**



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