PEGASUS
MEDICAL LOCUMS

Application form (BLOCK CAPITALS please)

Surname ..... Forenames .....

Title ..... (Dr/Mr/Mrs/Miss/Ms) .....

Present address .....

.....

..... Postcode .....

Tel ..... Work ext/bleep .....

Email ..... Mobile .....

Permanent address .....

.....

..... Postcode .....

Tel .....

Date of birth ..... M/F ..... Nationality .....

IDENTITY

We need to be able to confirm your identity – please indicate the original form of identity that you will provide.

Passport ☐ Birth Certificate ☐

ELIGIBILITY TO WORK IN THE UK

We need to ensure that you are eligible to work in the UK.

Visa status ..... Not required/indefinite leave/work permit/student

Visa number ..... Visa expiry date .....

REGISTRATION DETAILS

Date and place of medical registration .....

G.M.C. registration certificate no. ..... Expiry date .....

Medical defence society and no. ..... Expiry date .....

Which performers' list are you on? .....
(If applying for GP locum work)

Please attach photocopies of these certificates with your application.

WORK REQUIREMENTS

Grades .....

Specialities .....

Hours required ..... Locations .....

Area ..... Full/part time .....

Date you wish to commence work .....

Which medical magazines/journals do you read? .....

Which computer systems are you familiar with? .....

Where did you hear about Pegasus? .....

Qualifications	Where obtained	Date
(if your CV covers all information, please refer)		

Curriculum vitae enclosed Yes ☐ No ☐

TRAINING AND APPRAISAL

Please indicate any training you have undertaken:

Basic life support	Date	Infection control	Date .....
Caldicott protocols	Date	Manual handling	Date .....
Child protection	Date	MDA incidents	Date .....
Complaints handling	Date	Mental health act	Date .....
Handling violence	Date	Lone worker training	Date .....
Health and safety	Date	Risk incident reporting	Date .....
Other	Date		

RECORD OF IN-TRAINING ASSESSMENTS

Please indicate the gradings of any RITAs made in the past five years (if applicable).

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APPRAISAL ARRANGEMENTS

Name of appraiser .....

Position of appraiser .....

Date of last appraisal ..... Date of next appraisal .....

As detailed above, I hereby confirm that I have made formal arrangements to be appraised regularly, by a medical practitioner entered onto the Specialist Register or in the case of a GP locum by a medical practitioner who is, or is qualified to be, a GP Principal.

Name (please print) .....

Signed ..... Date .....

MEDICAL QUESTIONNAIRE

All applicants are required to complete this medical questionnaire.

GENERAL HEALTH QUESTIONS

Please answer all the following questions. If you answer yes, please give details.

	Yes	No	Details
1 Do you have any allergies?			
2 Have you seen a doctor in the last year for any kind of health problem?			
3 Are you taking any tablets or medicine?			
4 Have you ever had any mental illness or psychological problems?			
5 Do you have any impairment which may affect your ability to work safely?			
6 Have you ever had a hearing defect or do you wear a hearing aid?			
7 Have you any disabilities or are you registered disabled?			
8 Have you had any absence due to sickness in the last two years?			
9 Have you ever had a drug or alcohol problem?			
10 Have you had blackouts, epilepsy or fits?			
11 Have you ever had prolonged or severe backache or a neck/back injury?			
12 Have you ever had any kind of skin problem?			
13 Have you ever suffered from heart disease, angina or raised blood pressure?			
14 Have you ever had asthma, bronchitis, pleurisy or other chest problems?			
15 Have you ever had diabetes, thyroid or gland problems?			
16 Have you ever had a needlestick or mucous membrane injury?			
17 Do you have any other medical conditions?			

MEDICAL QUESTIONNAIRE

1 Have you had a Mantoux, Tine or Heaf test for T.B? If yes date .....

Have you had a BCG vaccination? If yes date .....

Have you been tested for T.B? If yes date .....

Result and date of most recent chest x-ray .....

2 Have you been immunised against:

Tetanus If yes date .....

Polio If yes date .....

Diphtheria If yes date .....

Mumps If yes date .....

3 Attach evidence of immunity to Hepatitis B.

4 Attach evidence of immunity to Rubella.

5 Attach evidence of immunity to Chickenpox.

6 For those doctors undertaking exposure prone procedures attach evidence of immunity to Hepatitis B and C from Occupational Health Department.

7 Have you tested positive for H.I.V? If yes provide details .....

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REFEREES

Name and address of 2 professional referees if not on CV (Please ensure they are within past 12 months).

1 .....

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Tel .....

Fax .....

Email .....

2 .....

.....

.....

.....

Tel .....

Fax .....

Email .....

DECLARATIONS

Rehabilitation of offenders Act

Due to the nature of the work for which you are applying, the provisions of section 4(2) of the rehabilitation of offenders Act 1974 does not apply by virtue of the rehabilitation of offenders Act 1974 (Exceptions) (Amendments order 1986). Applicants are, therefore, not entitled to withhold 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 to an application for positions to which the order applies.

Have you ever been convicted of an offence other than a road traffic violation, or are any such procedures pending? Yes ☐ No ☐

If yes, please give details .....

PROFESSIONAL MISCONDUCT

Have you ever been subject of professional misconduct proceedings or are any such proceedings pending or threatened against you?

Yes ☐ No ☐

If yes, please give details .....

AIDS/HIV INFECTED HEALTHCARE WORKERS

I confirm that I have read the Professional Regulatory Bodies Notice of Ethical Responsibilities contained in the booklet Occupational Guidance for AIDS/HIV Infected Healthcare Workers.

Yes ☐ No ☐

IONISING RADIATION CERTIFICATE

Do you hold an Ionising Radiation Certificate? Yes ☐ No ☐

Copy of Certificate enclosed? Yes ☐ No ☐

POLICE CHECKS

An enhanced CRB disclosure is required. Please fill in the forms attached and return with this application.

If you already have a certificate please attach it to this application form as well.

APPLICANTS FROM OVERSEAS

If you have taken up residence (or intend to take up residence) in the UK in the previous 6 months we require a 'Police Check' from your country of origin.

Date of check ..... Issued by .....

WORKING TIME DIRECTIVE OPT-OUT AGREEMENT

Regulation 4 of the Working Time Directive requires that a worker's average working time must not exceed 48 hours per week unless the worker agrees in writing to exceed the limit.

If temporary employees are to lawfully work more than 48 hours, they must sign an opt-out agreement to this effect.

If you are prepared to work more than 48 hours per week, please sign and return the agreement below as soon as possible in order that we may lawfully employ you even if your hours exceed this.

I agree to opt-out of Regulation 4 of the Working Time Directive.

Name (please print) .....

Signed ..... Date .....

DATA PROTECTION ACT

Under the Data Protection Act 1998 ("The Act") we are required to provide you with certain information and to seek your consent to the processing of personal data supplied by you on this form.

For the purposes of the Act the data controller in respect of personal data relating to you is Pegasus Medical Limited.

The purposes for which personal data supplied by you on this form are intended to be processed are as follows:

- To assess your skills, suitability and eligibility for employment
- To introduce you to our customers
- To update you with relevant information from time to time

We may retain certain personal data supplied by you on this form after you have ceased to be a member in order to comply with current legislation and client requirements.

I consent to the Company processing all or any personal data supplied by me on this form.

Name (please print) .....

Signed ..... Date .....

DECLARATION

I declare that the answers to the above questions are true and complete to the best of my knowledge and belief. I understand that making false statements or failure to declare a health problem could lead to dismissal.

Name (please print) .....

Signed ..... Date .....

SELF EMPLOYMENT

In the case of periods of self employment, please give details of your accountant, bookkeeper or solicitor. If you do not use the services of an accountant or bookkeeper please provide self assessment income tax forms.

Name .....

Current address .....

.....

..... Postcode .....

Tel .....

Occupation .....

Known from ..... to .....

FURTHER INFORMATION

Please use this space for any additional information and continue on separate paper if necessary.

PHOTOGRAPHS

PLEASE AFFIX PHOTO OF YOURSELF HERE

PLEASE AFFIX PHOTO OF YOURSELF HERE

BANK DETAILS

Name of bank .....

Address .....

.....

..... Postcode .....

Name of account holder .....

Account number .....

Sort code .....

Building Society roll number .....

National insurance number .....

P45 enclosed? Yes ☐ No ☐

P46 enclosed? Yes ☐ No ☐

DECLARATION

Please sign before returning

I declare that the information given herein is true complete and is not presented in a way intended to mislead. Furthermore, I am not aware of any condition, medical or otherwise, which would limit or affect my employment or performance.

I agree that if I give or have given false or misleading information, or omit to give relevant information, this may result in termination of assignment without notice.

I acknowledge that I have been given a copy of the current terms and conditions of service and that I have read those terms and agree to abide by them.

Name (please print) .....

Signed ..... Date .....

Next of kin and relationship .....

Telephone of next of kin .....

If yes please attach a copy of the certificate.