Nurse Application Form

PEGASUS
MEDICAL LOCUMS

- **Surname** _____ **Forenames** _____
- **Title** _____ **NMC Pin** _____
- **Present Address** _____

  _____
- **Postcode** _____ **Telephone** _____
- **Email** _____ **Mobile** _____
- **Date of Birth** ____/_____/_____ **M/F** _____
- **Nationality** _____

ELIGIBILITY TO WORK IN THE UK

Your entitlement for working as a Healthcare Professional 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 Healthcare worker Prior to 1985	☐

If you are an EEC Citizen please supply us with any of the following documents:

Original payslip with your National Insurance details Enclosed Evidence ☐ Birth Certificate or copy of Passport.
If your place of origin is outside the EEC, please provide supporting visa documentation and copy of passport Enclosed Evidence ☐

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 _____/_____/_____		

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 ☐

BANK DETAILS

Name of bank _____

Address_____

_____ Postcode _____

Name of account holder_____

Account number_____ Sort code_____

Building Society roll number_____

National Insurance number_____ Unique tax Reference_____

P45 Enclosed? Yes ☐ No ☐ P46 Enclosed? Yes ☐ No ☐

REFEREES

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

1 _____

_____

_____

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 ☐

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

_____

_____

WORKING TIME DIRECTIVE OPT-OUT AGREEMENT

Regulation 4 of the Working Time Directive requires that a workers 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 _____ **Dated** _____/_____/_____

DATA PROTECTION ACT

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

POLICE CHECKS

An enhanced DBS disclosure is required. Do you have a current DBS (Within 1 year old)? Yes ☐ No ☐

If you already have a certificate please attach it to this application form or contact our office and we can arrange a DBS for you.

ADDITIONAL INFORMATION

Which medical magazines/journals do you read? _____

Which computer system are you familiar with? _____

Where did you hear about Pegasus? _____

Curriculum Vitae 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 _____

Pegasus Medical Locums Limited
Tameway Tower, 48 Bridge Street
Walsall WS1 1JZ
Registered in England No. 7556019
VAT Registration No. 113 9929 01

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
Do you have any allergies?			
Have you seen a doctor in the last year for any kind of health problem?			
Are you taking any tablets or medicine?			
Have you ever had any mental illness or psychological problems?			
Do you have any impairment which may affect your ability to work safely?			
Have you ever had a hearing defect or do you wear a hearing aid?			
Have you any disabilities or are you registered disabled?			
Have you had any absences due to sickness in the last two years?			
Have you ever had a drug or alcohol problem?			
Have you ever had blackouts, epilepsy or fits?			
Have you ever had prolonged or severe backache or a neck/back injury?			
Have you ever had any kind of skin problem?			
Have you ever suffered from heart disease, angina or raised blood pressure?			
Have you ever had asthma, bronchitis, pleurisy or other chest problems?			
Have you ever had diabetes, Thyroid or gland problems?			
Have you ever had a needle stick or mucous membrane injury?			
Do you have any other medical conditions?			

MEDICAL QUESTIONNAIRE

1. Have you had 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 Nurses 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

_____

_____

Date _____/_____/_____

Print Name _____Signed_____