



TYPE or PRINT in black ink

POSITION APPLIED

PERSONAL DETAILS

Title: Mr Miss Mrs Dr Other

Surname:

First Name:

D.O.B: Marital Status:

Nationality: NI Number:

Address:

Postcode:

Contact Tel: Mobile:

Email:

PASSPORT DETAILS

Passport No: Place of Issue:

Issue Date: Expiry Date:

Visa Status: Visa Expiry Date:

If student, please provide the course details:

REGISTERED GENERAL NURSES ONLY

PIN No: Renewal Date:

Speciality: Band:

Current area work: Experience:

Preferred Shifts:

HEALTH CARE ASSISTANTS

NVQ: Yes/No. Level:

Preferred Shifts:

EDUCATIONAL QUALIFICATIONS

Place of Study	Qualification	Date Qualified

Use an additional sheet if necessary

TRAINING

Course Name	Date Attended	Expiry Date	Details(if necessary)

Use an additional sheet if necessary

WORK EXPERIENCE

From	To	Name of Employer	Type of Business	Job Title

Use an additional sheet if necessary

REFERENCE

Please give the names and contact details of two referees. One should be your previous Employer.

Name:	<input type="text"/>	Name:	<input type="text"/>
Job Title:	<input type="text"/>	Job Title:	<input type="text"/>
Relationship:	<input type="text"/>	Relationship:	<input type="text"/>
Address:	<input type="text"/>	Address:	<input type="text"/>
Company Name:	<input type="text"/>	Company Name:	<input type="text"/>
Tel:	<input type="text"/>	Tel:	<input type="text"/>
Email:	<input type="text"/>	Email:	<input type="text"/>

EQUAL OPPORTUNITY MONITORING FORM

The information on this form will be used in total confidence and accordance with current data protection legislation. It will help to ensure that the company properly monitors and confirms with its policies relating to equality of opportunity. Information will be used for monitoring only. Our commitment aims to allow our staff to develop their skills and realize their maximum potential as individuals without any wish on the part of the company to limit their opportunity.

PLEASE TICK THE RELEVANT BOX

White Mixed Asian Black Chinese Other

Gender: Male Female

Please Indicate your age range by ticking one of the boxes below :

16-21 22-25 26-30 31-35 36-40 41-50 51-60 61-65

Do you consider yourself to have a disability of some kind ?

Yes No

If Yes, give details

PROTECTION OF CHILDREN AND VULNERABLE ADULTS DECLARATION

Has any Social Service Department or Police Service ever conducted an enquiry or investigation into any allegations or that you may pose an actual or potential risk to children or vulnerable adults? Yes No

Have you ever been convicted of any offence relating to children or vulnerable adults? Yes No

Have you ever been the subject of any disciplinary procedure or been asked to leave employment or voluntary activity due to inappropriate behavior towards a child or vulnerable adult? Yes No

If no please sign the declaration below. If yes to any of these questions above, please give details.

REHABILITATION OF OFFENDERS

Because of the nature of the work for which you are applying, this post is exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974, by virtue of the Rehabilitation of Offenders Act 1974 (Exemptions) 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 by the employer. All Successful candidates will be required to obtain an enhanced disclosure report from the Disclosure and Barring Service. Have you ever been convicted of a criminal offence, or been subject to any confidential discharge, bind overs or caution.

Yes No

If no please sign the declaration below, If yes please give details

I declare that I do not possess, nor have I ever possessed a criminal conviction, nor have I been subject to any conditional discharges, bindovers or cautions.

Signature

Date

Any information contained in this form will be treated in confidence. Failure to disclose any relevant information or providing false or inaccurate information may be regarded as a breach of any subsequent contract of employment, resulting in disciplinary action and/or dismissal.

HEALTH CHECK QUESTIONNAIRE (optional/to be filled upon selection)

GP Contact Details:

Please answer all the following questions by giving relevant details

1. Have you ever suffered from any of the following:

- a) Depression, anxiety state, nervous illness or breakdown No if Yes,
- b) Epilepsy or disease of the nervous system No if Yes,
- c) Ailment of lungs or chest No if Yes,
- d) Spinal problem (backache) No if Yes,
- e) Arthritis, Rheumatism or Gout etc No if Yes,
- f) Any heart or circulatory, including blood problems No if Yes,
- g) Illness of the kidneys, bladder, liver or glands No if Yes,
- h) Diabetes No if Yes,
- i) Skin disorder No if Yes,

2. Are you presently taking medication or undergoing treatment. If so give details:

3. How many working days have you been absent from working during the last 12 months (apart from holidays)

4. Are you now pregnant?

No

Yes

N/A

5. Additional details: (if necessary)

PAYMENT DETAILS

Please provide your bank details where you would like your payment to be sent.

Bank / Building Society Name and Address:

Account Number:

Sort Code:

Name in Account:

Type of Account:

DECLARATION

I confirm that the information given within this form is true and accurate. I hereby give consent for this information being used for personnel administration and business purposes.

Signature

Date

Name

Once completed please send it to the respective branch.

FOR OFFICIAL USE ONLY (Application Check List)

Address with Postal Code:

Telephone & E-mail:

Qualification Certificates:

NI Number:

Passport Details:

Visa Details:

References:

Training:

DBS:

NOTES:

Checked by:

Date: