19, Anson Drive, Southampton, Hampshire. SO19 8RP. United Kingdom
Tel: 02380 448187 | Fax: 02380 448187
Website: www.bayviewhealthcare.co.uk Email: info@bayviewhealthcare.co.uk

NURSES APPLICATION FORM

PERSONAL DETAILS

Title: Surname

Forename: Maiden Name

Middle Maiden: Marital Status:

Date of Birth Male Female:

Age: National Insurance:

Address:

City / Town Country

Postcode: Home Telephone:

Mobile phone: Work Phone:

Page No Email Address:

Preferred Contact Method

Are you willing to expect Morning calls? Yes No:

Are you willing to expect late Night Calls? Yes: No

VARIOUS INFORMATION

Work status Passport Number: Exp date:/

Nationality Birth certificate No:

Home Office Letter ref: Have Work Permit? Yes No

Work Permit Type Expiry Date:

Name of College/University (if student)

Studying Nursing?: Yes No If yes, when do you graduate?:

Are you undergoing Adaptation?: Yes No

If yes, Give Your Completion date

Have your own transport? Type of Transport:?

Have you a Driving License?:Yes / No If yes any endorsement?

Religion Ethnic Origin

Children under 18 years? Yes / No Ages

Do you smoke? Yes / No Registered Disabled? Yes No

Registration No:

Give details of Hobbies/ Leisure Activities

PROFESSIONAL EDUCATION AND TRANING.

Please list any Training / Course / Nursing qualification you have and when you gained them

Qualification: School / College University Dates Gained

…… …… ……

…… …… ……

…… …… ……

…… …… ……

…… …… ……

…… …… ……

NMC Pin No

Where obtained:

Registration date: Expiry Date ……

Please Tick The Nursing Specialities of which you have significant post-training experience. Please remember you will be held accountable for any missing information.

SPCIALISM (Nursing)	LESS THAN 6 MONTHS	MORE THAN 6 MONTHS	1- 2 YEARS	2 YEARS +
Medical				
Learning Disability				
ITU Psychiatric				
Intensive Care Unit				

In-charge Duties				
Hospitals				
Hospices				
Home Care				
High dependency Unit				
Health Visitors				
Haematology				
Gynaecology				
GU Med				
Dental				
District Nursing				
Family planning				
Urology				
Mental Health				
Stoma Care				
Theatre				
Renal				
Residential Homes				
Paediatric				
Oncology				
Midwifery				
Nursing Homes				
Out patients				
CSSD				
Neonatal				
Care of the elderly				
Practice Nurse				
GU Med				
Recovery				
Prisons				
Surgical				
Occupational Health				
Mental health				
Orthopaedics				
PICU				
SCBU				
A & E				
Cardiac				
ODP /ODA				
Neurology				
Radiology				
Scrub				
Theatre				
Day Surgery				
Intensive Care Unit				
Day Care Centre				
School Nurse				
Ante Natal				
Cardiothoracic				
Chemotherapy				

Anaesthetic Trained				
Medical Assess unit				

MID WIVES ONLY

Midwives Please Circle The Appropriate Box If Practising Yes No

Intention to practice completed?: Yes No

Expiration Date / /

EMPLOYMENT HISTORY

Please Give Details Of Your Past 5 years Of Continuous Work History Giving Reason/s For Any Breaks In Employment.

From / / To / / Employer

Address

Telephone: Main contact

Post Title: Grade

Full time or part-time Salary:

Main responsibilities:

Dept / ward:

Reason for leaving:

From / / To / / Employer

Address

Telephone: Main contact

Post Title: Grade

Full time or part-time Salary:

Main responsibilities:

Dept / ward:

Reason for leaving:

From / / To / / Employer

Address

Telephone: Main contact

Post Title: Grade

Full time or part-time Salary:

Main responsibilities:

Dept / Ward:

Reason for leaving:

From / / To / / Employer

Address

Telephone: Main contact

Post Title: Grade

Full time or part-time Salary:

Main Responsibilities:

Dept / Ward:

Reason for Leaving:

Have you ever been dismissed from a job? YES NO

If Yes, Why?

HEALTH DECLARATION

To be completed by all applicants.

Have You Been Vaccinated Or Tested Against The Following:?	YES	NO	DETAILS (Plus dates if YES)
Hepatitis B			
HIV			
Tetanus			
Poliomyelitis			
Typhoid			
Rubella (German Measles)			
Tuberculosis and BCG			
Hepatitis B Antibodies			
Mantoux, tine or Heaf			
Varicella			
Last X-ray			
Others (Specify)			
Do You Or Have You At Anytime Suffered From Any Of The Following?	**YES**	**NO**	**Details. (Required If YES)**
Skin complaints- dermatitis, Psoriasis, Eczema			
Diabetes or glandular complaints			
Headaches or Migraine			
Hypertension/ heart problems/ similar illness			
Back pains / Back injury or problems			
Jaundice / Hepatitis			
Epilepsy or fainting attacks			
Pleurisy /Bronchitis / Pneumonia			
Asthma			
Infections - ear / sore throat			
Psychiatric/ Mental disorder/ depression etc			
At present Are You Having Any			

injections/medications	YES	NO	Details (if YES)
Are you under any treatment of any kind of condition?			
Have you had any major operations?			
Physical Disabilities?			
How much time have you taken off work in the Last 5 years due to illness?.			
Please state any other information about your health which may affect your work			
If you do not have vaccination information , please provide details of where we can request them below.			

I certify the above information is correct and hereby give permission to Bayview Healthcare to request a further report from my GP/ Occupational Health/ Hospital for clarification if required and for my health report

GP /Occupational Health/ Hospital .....

Address .....

.....

Tel: ..... Mobile .....

Email address: .....

Signed (Applicant) .....

WORK PREFERENCE

What kind of Nursing/Care work are you interested in? (tick all that apply)

NHS PRIVATE HOSPITAL NURSING HOME

RESIDENTAL HOME: OTHERS

(Please specify) SHORT TERM LONG TERM

Please indicate when you would like to work. Please tick all relevant boxes.

DAILY.

PART-TIME FULL-TIME BANK HOLIDAYS

EVENINGS (M-F) DAYS (M-F) NIGHTS (M-F)

EVENINGS (SAT-SUN) DAYS (SAT-SUN) NIGHTS (SAT-SUN)

AVALIBILITY

From when are you available to work? Come for an interview?

Do you have any holiday booked? When:

.....

REHABILITATION OF OFFENDERS ACT 1974.

Because of the nature of the work for which you are applying, this post is exempt from the provisions of section 4.2 Rehabilitation of Offenders Act 1974 (Exemption Order 1975). Applicants are therefore, entitled to withhold information about convictions, which for other purposes are 'spent' under the provision of the Act in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action. Information provided will be kept confidential and use in relationship to the post applied for..

Have You Ever Been Convicted Of A Criminal Offence? YES……..NO……

If yes, please specify

.....

.....

.....

Do You Have Any Spent Or Unspent Convictions? YES NO

If yes, please specify .....

.....

.....

.....

Have You Instigated An Enhanced Disclosure Within The Last Six Years? YES/NO

I Consent To **Bayview Healthcare** Checking The Details I Have Provided Against The Various Data Sources In Order To Verify My Identity And Process This Application. These Details Maybe Use To Assist Other Organisation Such As DBS/CRB, NMC for Identity/Fitness-to-Practice Purposes.

SIGNATURE **DATED**

REFERENCES.

Please give the names and addresses of two of most recent employers with work addresses who are able to comment on your work ability and experience, starting with your present to most recent employer if possible.

(A)

Name of Reference:

Company Name and Address:

Postcode: City/ town; Country

Telephone no: Fax no:

Email address: Mobile phone:

Start date: / / End date: / / To date

(B)

Name of Reference:

Company Name and Address:

Postcode: City/ Town; Country

Telephone no: Fax no:

Email address: Mobile phone:

Start date: / / End date: / / To date

BUILDING SOCIETY /BANK DETAILS

Bank Name

Bank Address

Building Society Bank Roll

Account Holder's Name

Sort Code Account No

I authorise Bayview Healthcare to pay my weekly wages into the above Bank Account and I will notify Bayview Healthcare if changes occur to my details.

Signed **Date**

NEXT OF KIN

Name of Emergency contact

Relationship to you:

Address:

Post Code : Home Telephone:

Work No: Email Address:

Mobile No Pager No

WORKING TIME REGULATIONS

I have read and understood the Working Time Regulations and I hereby consent that the working time limit shall not apply to my assignments

Print Name .....

Signed ..... **Date** .....

FINAL STATEMENT

I declare that the information provided on this application form is true to the best of my knowledge. I have read the terms and condition of engagement and agree to comply with the current Health and Safety at Work Act. I understand that my appointment is subject to the receipt of two satisfactory references and also subject to Enhanced CRB Disclosure. **Bayview Healthcare** is free to make any other enquiries they may find necessary relating to my application. I agree to respect the confidentiality of patients and clients and any other information I may have access to.

Signed ..... **Date** .....

AGENCY INFORMATION. OFFICE USE

CHECKLIST		**NOTES**
Application		
Proof of Address	Utility bills, bank statements, others.	
Proof of identity	Passport, driving license others	
Eligibility to work	Visa, Work Permit,, passport, birth cert	
NMC Pin No + Expiry date.		
DBS / CRB Application		
48 hours opt out		
PAYE Form		
2 passport photographs		
Immunisation		
Signed contract		

AGENCY SIGN OFF

I Certify that I interviewed the above applicant in accordance with the **Bayview Healthcare** requirements and I am satisfied that this applicant is cleared for work.

Name Of Consultant _____

Signature Of Consultant _____

Date _____