kcaremedicallocum

*We'll be there for **You***

Name:

Ref. No:

Application form

PRIVATE AND CONFIDENTIAL

Position:

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Document checklist

Please complete the application form and return it to our office. You may register any time between 8am and 8pm Monday to Friday.

To help us with your application please answer the questions within this form in black ink. Once you have finished please return your completed application form to the address above. If you have any problems with any of the questions, please contact our office. Our consultants will be more than happy to assist you with your application.

You will be expected to bring the following for us to help you with your application form:	
2 Passport size photographs (If not attached to page 1 of this form)	
Documentation of your National Insurance Number i.e. NI Card, P60, P45 or other official Inland Revenue documents	
ALS/BLS and Advanced/Basic Life Support Training Certificate Copy	
Proof of professional indemnity insurance	
Proof of identity (passport or full birth certificate only if British) I.D (Other proof of identity)	
Work Permit or Visa (if required)	
Two forms of proof of current address are required for the Criminal Records Bureau disclosure e.g. utility bill, bank statement	
Vaccination report from your GP or Occupational Health Department i.e. Hepatitis B, Varicella (chicken pox) Measles, Mumps, Rubella (German measles), Tuberculosis, HIV, Hepatitis C	
Completed Enhanced disclosure (CRB) form Due to the new legislation on POVA (Protection of Vulnerable Adult) listing, a new CRB has to be done when you are joining the Agency.	
Copies of certificates in relevant field	
Post qualification certificates relevant to practice	
GMC Statement of entry.	
Police Check from home country	
Drivers Licence i.e. only if you are using a car during the work	

IT IS A REQUIREMENT OF THE AGENCY THAT YOU ARE ABLE TO READ, SPEAK AND UNDERSTAND THE ENGLISH LANGUAGE. But other language skills are welcome.

*Copies of original must be seen and copied and you must present the official translation of any documents not written in English. The translation must be done by a certified translator.

PLEASE ENSURE YOU BRING ALL REQUESTED DOCUMENTATION WITH YOU WHEN YOU COME TO REGISTER.
OUR CONSULTANTS WILL NOT BE ABLE TO REGISTER YOU WITHOUT THEM.

K-Care Medical Locum
155 Oxford Road, Reading, Berkshire RG1 7UY

Tel: 0845 0038397
Fax: 01189 584598

Email: info@kcarehealth.com
Website: www.kcarehealth.com

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Registration form

Personal Details

Please attach a passport size photograph and clearly print your name on the reverse of each

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Surname: (as in your passport)**:**	**Forename:** (as in your passport)**:**
Previous names: (Inc maiden name)**:**	**Title:**
Contact Details:	
Current address:	
Post Code:	Country:
Home Tel:	Email:
Mobile:	Other:
Date of Birth: (for Payroll purposes ONLY)	Nationality (at Birth):
Nationality (at Present):	Work Permit Required: YES / NO
N I Number:	Are you currently on a Work Permit? YES / NO
Do you hold an ionizing radiation certificate? YES / NO Grade: Specialty:	
Who should we contact in an emergency?	
Surname:	First name:
Relationship:	Tel number:
Next of Kin (if different from above):	
Surname:	First name:
Relationship:	Tel number:

Registration form (continued)

Right to work in the UK

EU Citizen: **YES / NO**	Admitted in the UK as a Doctor before 1. April 1985: **YES / NO**	
Spouse of EU Citizen: **YES / NO**	Work Permit Number:	Expiry Date:
Right of abode in the UK: **YES / NO**	Permit-free Visa: **YES / NO**	Expiry Date:

Criminal Convictions/Fitness to Practice Declaration

Have you been convicted of a criminal offence, been bound over or cautioned, or are you currently the subject of a police investigation, which might lead to a conviction, an order binding you over, or a conviction in the UK or any other country?
YES / NO

If ´**yes**´ please provide details of the criminal offence, the order binding you over, the caution or details of any current proceedings which might lead to a criminal conviction, including approximate date, the offence, and the authority and country that dealt with the offence. If applicable, include details of "Spent Convictions" on a separate sheet.

Note: Applicants for posts in the NHS are exempt from the rehabilitation of Offenders Act 1974. You are required to declare prosecution or convictions, including those considered ´spent´ under this act.

Have you been or are you currently the subject to any ´Fitness to Practice´ proceedings by an appropriate licensing or regulatory body in the UK or any other country? **YES / NO**

Have you been suspended from duty with any organisation or with the GMC? **YES / NO**

If you have answered ´**yes**´ to either of the above, please provide details of the nature of the proceedings undertaken, or contemplated, including approximate date of the proceedings, country where proceedings were undertaken, and the name and address of the licensing or regulatory body concerned.

I declare that, if in the future, I am convicted of a criminal offence, bound over or cautioned, under investigation by the GMC, the subject of any ´Fitness to Practice´ proceedings, or suspended from duty by any other employer or agency, I will inform Kcare Medical Locum immediately.

Signed:	**Date:**

Professional Indemnity

We recommend that you take membership of a Medical Defence Organisation. If you are already a member please provide details of your membership. Please forward a copy with your application.

Defence Body:	Policy Number:
Expiry Date:	

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Grade

Are you on the Specialist Register? **YES / NO**

If ´**yes**´, I declare that I have made formal arrangements to be appraised regularly by a Medical Practitioner entered onto the Specialist Register and enclose a copy of my Letter of Entry.

NTN/VNTN Number if on SpR Training

GMC Number:	**GMC Renewal:**

I declare that I will make, and keep Kcare Medical Locum informed of all the necessary arrangements to remain on the License to Practice Register of the GMC.

Signed:	**Date:**

Qualifications

Please provide details of academic and professional qualifications. (Please provide copies of certificates).

Basic:	Date:
Country of issue:	
Higher/ Postgraduate:	Date:
Country of Issue:	

Referees

Please provide details of at least three referees two of which must be from your most recent engagements held . One of your references must be able to support the grade and specialty you wish to work at.

All references supplied must be from a supervising Consultant with whom you have worked within the last 12/18 months and support the grade and specialty you wish to work at

1. Title:	**2.** Title:	**3.** Title:
Name:	Name:	Name:
Speciality:	Speciality:	Speciality:
Address:	Address:	Address:
Telephone:	Telephone:	Telephone:
Email:	Email:	Email:

Health Declaration – Part 1

Personal

Title:	Forenames	Surname
Address:		
GMC Number:	Date of Birth:	Gender: **M / F**

Required Immunity Evidence

We require copies of pathology reports for: (please circle)	Enclosed
Hepatitis B: - Titre level and Surface Antigen	**YES / NO**
Hepatitis C: - Antibody	**YES / NO**
Rubella: - Igg Antibody	**YES / NO**
Varicella	**YES / NO**
TB:	**YES / NO**
Measles:	**YES / NO**
Mumps:	**YES / NO**
HIV:	**YES / NO**

We require declared or pathology evidence for the following: (please circle)	Enclosed
Have you had Varicella (Chicken Pox)?	**YES / NO**
Have you had blood taken to determine your immunity?	**YES / NO**
Have you had a BCG immunisation (TB)?	**YES / NO**
If no, have you had a Heaf/Mantoux	**YES / NO**

Attendance Record

Have you had any absences from work in the last 2 years?	**YES / NO**
If “yes” please give details of: (Please use a separate sheet if necessary)	
Number of absences:	
Length of each absence:	
Reasons for each absence:	

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Declaration

I understand that information contained within this document is governed by the Data Protection Act 1998 and that disclosure of information will occur only in relation to employment opportunities. I understand that you may direct essential information to my potential employer and make recommendations regarding my health and the hazards and risks of my employment, with due reference to other relevant statutory requirements and professional practice.

I confirm that I am aware of the GMC’s statement with regard to the duties of doctors infected, or who have reason to believe they may be infected with the HIV virus and agree to notify Kcare Medical Locum should my circumstances alter.

I confirm that I am aware of the NHS guidance and recommendations with respect to serious communicable diseases, including Rubella, Varicella, TB, Hepatitis B and Hepatitis C and agree to notify my employing hospital and Kcare Medical Locum should I have any reason to suspect that I may be a risk to patients, carers or other healthcare workers.

I declare that I will maintain up to date immunity at a minimum of 5-year intervals and forward evidence of such immunity to Kcare Medical Locum.

I understand that details of my occupational health information and copies of laboratory reports may be sent to any hospital where I may be assigned. I authorise Kcare Medical Locum to obtain any further information from hospitals or Occupational Health Departments as necessary.

Doctor’s Signature	Date:

for Kcare Medical Locum Internal Use Only	
Print Name:	OHA Signature
Date:	OHA Signature

Health Declaration – Part 2

Only our Occupational Health Advisor will view this section of the Health Declaration. It will remain confidential and will not be disclosed to any external organisations without your prior written consent.

Thank you for your cooperation.

Health History

A) Do you have a health issue for which you are currently receiving medication?	**YES / NO**
If yes, please write a short written statement in the blank space below.	
B) Do you have a past health issue in hour medical history about which an employer should or might wish to know?	**YES / NO**
If yes, please write a short written statement in the blank space below.	

Signature:	**Date:**

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Tax Status

Please select one of the following:

1. PAYE:	**YES / NO**
P45 enclosed:	**YES / NO**
P60 enclosed:	**YES / NO**
NI Number	

2. LTD Co:	**YES / NO**
Company Name:	
VAT Registered	**YES / NO**
Enclose Certificate of Incorporation Enlcose Ltd Co Bank Statement	

3. Self Employed Professional	**YES / NO**
NI Number:	
UTR Number:	**YES / NO**
If no UTR number is available, please confirm in writing that you are registered as self employed with the Inland Revenue giving your tax office address	

Doctor's Declaration

(Please sign all sections of this document *delete as applicable)

Health

I declare that I am in good physical and mental health, and I know of no health reasons that prevent me from accepting agency locum assignments.

Signature:	**Date:**

Entitlement to Work in the UK

I declare that I know of no reasons that prevent me from accepting agency locum assignments that are appropriate to my current entitlement to work in the UK.

Signature:	**Date:**

Your General Practitioners Details

Name:	
Address:	
Post Code:	Telephone:

Appraisal Details

Please supply name of Medical Practitioner/GP principle who is entered on the specialist register with whom formal arrangements have been made to be regularly appraised*:

Doctor's Name:
Date last appraised**:
Date of next appraisal:
*Please supply details of your Continual Professional Indemnity (CPD) action plan. **Please supply a copy of the transcript of your last appraisal.

Vocabulary:

1. NTN/VNTN Number: Registration number for Specialist training.
2. OHA: Occupational Health Assessment.
3. If **Yes**, I declare that I have made formal arrangements to be appraised regularly by a Medical Practitioner entered onto the Specialist Register and enclose a copy of my Letter of Entry.
4. I have Home Office and Department of Employment entitlement to work through an agency in the UK. I declare that I know of no reasons that prevent me from accepting agency locum assignments that are appropriate to my current entitlement to work in the UK.

Equal Opportunities Monitoring Form

Kcare Medical Locum is committed to fairness and equality of opportunity in employment, within the Council as well as in service provision. The Agency's Equalities Policy states that:

"Kcare Medical Locum will promote equal opportunities for all section of the community and will combat discrimination and disadvantage. We will not discriminate against anyone unjustifiably on any ground."

In pursuit of the policy, we monitor the make-up of the workforce to ensure that we are not carrying out practices that result in unfair selection, recruitment, access to training and promotion.

To ensure that the Kcare Medical Locum's equal opportunities policy is being implemented and to comply with legislation, please complete and return this form. This information will be used solely for monitoring purpose and will not be available to those involved in the selection process.

Second Name:	Post title as advertised:
First Name:	Location/workbase:
Date of birth:	Date:
Female ☐ Male ☐	
Where did you see this post advertised?	

How would you describe your ethnic origin? (please tick the appropriate box - using new recommended categorization). Please understand that this question is not about nationality, place of birth or citizenship.

Asian or Asian British		**Black or Black British**		**Mixed**		**Other Ethnic Groups**		**White**	
Indian		Caribbean		White & Black Caribbean		Chinese		British	
Pakistani		African		White & Black African		Any other ethnic group		Irish	
Bangladeshi		Any other black background		White and Asian				Any other white background	
Any other Asian background				Any other mixed background					

Under the Disability Discrimination Act 1995, a person has a disability if he/she has a physical or mental impairment which has a substantial and long-term adverse effect on his/her ability to carry out normal day-to-day activities.

Do you consider that you have a disability?	**YES / NO**
If Yes, please state nature of disability, and how, if at all, it affects your performance at work.	

Signature:	**Date:**

Any information held on this form will be subject to the Data Protection Act 1984 and 1998