Name:

Ref. no:

Application form

Private and confidential

Position:

Kcare nursing

we'll be there for YOU

kcarenursingagency

155 Oxford Road, Reading, Berkshire RG1 7UY
Telephone: 0118 956 9922 Facsimile: 0118 958 4598 Email:

kcarenursingagency

Please complete the application form and return it to our office.
You may register any time between 9am and 5pm 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 our office.
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)	☐ Vaccination/Serology report from your GP or Occupational Health Department i.e. Hepatitis B, Varicella (Chicken pox), Rubella (German measles), Measles and Mumps.
☐ Proof of identity (passport or full birth certificate only if British)	☐ Completed Enhanced Disclosure Form (CRB) 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.
☐ Work Permit or Visa (if required)	☐ Proof of ionising radiation certificate
☐ Documentation of your National Insurance Number i.e. NI Card, P60, P45 or other official Inland Revenue documents	☐ NMC PIN card, if you are a Nurse
☐ Drivers License	☐ Name and number must correspond with NMC PIN card.
☐ Two forms of proof of current address are required for the Criminal Records Bureau disclosure e.g. utility bill, bank statement	☐ NMC Statement of Entry
☐ Letter from your College/University, if you are a Student	☐ Post qualification certificates relevant to practice

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.

*If you have not obtained these certificates or your certificates need updating, Kcare runs courses in these subjects and you can book a place on these courses to speed your registration.

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.

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

1.0 Your Personal Details:

Surname:_____ Forename: _____

Previous names:_____ Title: _____
(Inc maiden name)

Contact Details:

Current address: _____

_____

County: _____

Post code: _____

Home Tel:

Mobile:

Other:

Email:

Date of Birth:_____

For Payroll Purposes ONLY

Nationality (at Birth): _____

Nationality (at present): _____

Passport No: _____

Date of Issue: _____

Place of issue: _____

Date of expiry: _____

Work Permit/Visa: Yes / No/NA

Date of expiry: _____

Marital status:_____

Position applied for:_____

N I number:_____

Who should we contact in an emergency?

Surname:_____

First name:_____

Relationship:_____

Tel number 1:_____

Tel number 2:_____

Next of Kin (if different from above):

Surname:_____

First name:_____

Relationship:_____

Tel number:_____

Tel number 2:_____

1.2 Your Personal Details (cont.)

Rehabilitation of Offenders Act

By virtue of the Rehabilitation of Offenders Act 1974 (Exemptions) Amendments Order 1986, the provision of section 4.2 of the Rehabilitation of Offenders Act 1974 does not apply to any employment which is concerned with the provision of health services and which is of such a kind as to enable the holder to have access to persons in receipt of such services in the course of his/her normal duties. Your answer to the following questions should include any spent convictions. This may or may not affect your application. All Nurses and Care Staff will be asked to apply for an Enhanced Disclosure with the Criminal Records Bureau as part of the recruitment and selection process.

Have you ever been convicted of a criminal offence? ☐ Yes ☐ No

If 'Yes', please give details: _____

Date of conviction: _____

Nature of conviction: Please continue on 'Section 7.0 Your Notes' or on a separate sheet if required

_____

_____

Are you currently the subject of criminal proceedings?

(e.g. charges or summons that are not yet being dealt with)? ☐ Yes ☐ No

If 'Yes', please give details: _____

Date of conviction: _____

Nature of conviction: Please continue on 'Section 7.0 Your Notes' or on a separate sheet if required

_____

_____

Have you ever been dismissed from a nursing post? ☐ Yes ☐ No

If 'Yes', please give details: _____

Date of dismissal: _____

Nature of dismissal: Please continue on 'Section 7.0 Your Notes' or on a separate sheet if required

_____

_____

Are you currently suspended, on notice of dismissal from employment or under investigation from any employer?

☐ Yes ☐ No

If 'Yes', please give details: Please continue on 'Section 7.0 Your Notes' or on a separate sheet if required

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Are you currently on maternity leave? ☐ Yes ☐ No

Do you belong to a union or professional body? ☐ Yes ☐ No If yes, which: _____

Do you have professional indemnity cover? ☐ Yes ☐ No If yes, which type:_____

Do you belong to any other agencies or staff banks? ☐ Yes ☐ No

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2.0 Your Work Preferences	
How many hours would you like to work with us?	Which areas would you like to work in?
Full time ☐	Medical wards ☐

Part time	☐	Surgical wards	☐
Days	☐	Acute	☐
Nights	☐	Psychiatric	☐
Weekdays	☐	Paediatrics	☐
Weekends	☐	Clients in their homes	☐
Any of the above	☐	Nursing Homes	☐
		Learning Disabilities	☐

Are you a car owner? Yes / No Do you have a full British Driving License? Yes / No

If not, state details:_____

Motor Insurance No:_____ Insurance Provider:_____ Expiry:_____

You have the option to opt out of the 48 hour working week limitation as laid out in the Working Time Regulations 1998. Please indicate one of the following:

I wish to opt out ☐ I do not wish to opt out ☐

If your circumstances change, please inform the office in writing allowing a 14 day notice period.

3.0 Your Qualifications

Please continue on 'Section 7.0 Your Notes' or on a separate sheet if required

Have you completed any of the following courses? (Please tick):

Control & Restraint Yes/ No Dates:_____ Managing Challenging Behaviour Yes/ No Dates:_____

Manual Handling Yes/ No Dates:_____ First Aid Yes/ No Dates:_____

NVQ Yes/ No Dates:_____ Food Hygiene Yes/ No Dates:_____

CPR Yes/ No Dates:_____ Health & Safety Yes/ No Dates:_____

3.1 Other Courses (please specify):

Course	Date	Where taken	Certified
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐

3.2 To Be Completed By Registered Nurses Only

We need to know your qualifications. These are to include details of NMC registration, Post registration qualifications and any other qualifications that you think are relevant.

NMC PIN number: _____ Part of register:_____ Expiry:_____

Name of training Hospital or University		Date	Qualifications

3.3 Competency & Accountability

Please tick the areas you are competent and confidant to work in

- ☐ A & E
- ☐ Anaesthetic Trained
- ☐ Autism
- ☐ Cardiac
- ☐ Cariothoracic
- ☐ Care of the Elderly
- ☐ Challenging Behaviour
- ☐ Chemothearpy
- ☐ Clinics
- ☐ CSSD
- ☐ Community
- ☐ District Nursing
- ☐ Day care centres/hospitals
- ☐ Diabetic Care
- ☐ EMI
- ☐ Eating disorder
- ☐ General
- ☐ Dental
- ☐ Gynaecology
- ☐ Haematology
- ☐ HDU
- ☐ Health Visitor
- ☐ Home Care
- ☐ Hospices
- ☐ Hospitals
- ☐ ITU
- ☐ ITU Psychiatric
- ☐ In Charge Wards
- ☐ In Charge Nursing homes
- ☐ In Charge Residential homes
- ☐ Learning Disability
- ☐ Medical
- ☐ Mental Health
- ☐ Midwifery
- ☐ Neonatal
- ☐ Neurology
- ☐ Nursing Homes
- ☐ Occupational Health
- ☐ ODP
- ☐ Oncology
- ☐ Ophthalmology
- ☐ Orthopaedics
- ☐ Palliative Care
- ☐ Practice Nurse
- ☐ Plastic Surgery
- ☐ Paediatrics
- ☐ PICU
- ☐ Prisons
- ☐ Radiology
- ☐ Recovery
- ☐ Renal
- ☐ Residential Homes
- ☐ Respite Care
- ☐ SCBU
- ☐ School Nurse
- ☐ Senior Care
- ☐ Social Care
- ☐ Social Worker
- ☐ Support Worker
- ☐ Surgical
- ☐ Terminal Care
- ☐ Training
- ☐ Theatre
- ☐ Urology

☐ Other (please specify) ……..

CARE ASSISTANTS

Please tick the areas you are competent and confidant to work in

- ☐ Catheter Care
- ☐ Fluid Charts
- ☐ Observations BP
- ☐ Observations TPR
- ☐ Urinalysis
- ☐ Use of Hoists

THEATRE STAFF

Please tick Courses and Certificates held

- ☐ Anaesthetic Trained
- ☐ ODA
- ☐ ODO
- ☐ ODP
- ☐ Any other ……
- ☐ ……..

SCRUB NURSES

- ☐ Cardiothoracic
- ☐ Dental
- ☐ Day surgery/scopes etc
- ☐ Endocrinology
- ☐ ENT
- ☐ General
- ☐ Gynaecology
- ☐ Neurology
- ☐ Ophthalmic
- ☐ Orthopaedic
- ☐ Plastic Surgery
- ☐ Recovery
- ☐ TOP
- ☐ Urology
- ☐ Vascular

EXPERIENCED IN:-

- ☐ Anaesthetics
- ☐ CSSD
- ☐ A&E Minor Injuries
- ☐ Blood obs & charting
- ☐ Catheterisation M/F
- ☐ Dinomaps
- ☐ Emis Computer System
- ☐ Gemini Pumps
- ☐ Oncology Drugs
- ☐ Peg feeds
- ☐ Removal of CVP Line
- ☐ Stoma Care
- ☐ Thyriodectomey Care
- ☐ Insertion of Laryngeal airway
- ☐ IV Cannulation
- ☐ Ability to Plaster
- ☐ Boots Monitoring Drug System
- ☐ Control & Restraint
- ☐ Drug Rounds/Medication
- ☐ Escort Duty (Blue light)
- ☐ Graseby's Pumps
- ☐ Out Patients Clinic
- ☐ Pressure air care
- ☐ Resuscitation A&E
- ☐ Suture & Clip Removal
- ☐ Use of most Pumps on market
- ☐ Acute Behavioural Problems
- ☐ Anaphylactic shock
- ☐ Baby Immunisation
- ☐ Care Plans/ Assessment
- ☐ CVP Readings
- ☐ Eating Disorders
- ☐ Flowtrons
- ☐ Ilostomy Care
- ☐ Passing Naso-Gastric Tubes
- ☐ Recording & Charting of BM's
- ☐ Sliding scale/ Reporting
- ☐ Syringe Drivers
- ☐ Ventilated Patients
- ☐ PCA's & Calibration
- ☐ Running in theatre
- ☐ Baxter pumps
- ☐ Cassette Drug System
- ☐ Dental
- ☐ ECT Treatment
- ☐ Forensic Medicine
- ☐ Nara Gastric feeding
- ☐ PCA inc Settings/Checks
- ☐ Redivac Care
- ☐ Smear Tests
- ☐ Tracheotomy Care
- ☐ Other:……

TRAINED NURSES

Please tick Courses and Certificates held

- ☐ A&E Course
- ☐ Advanced Life Support
- ☐ Critical Care Course
- ☐ IV Cannulation
- ☐ Mental Health Courses
- ☐ Paediatric Advanced Life Support

3.4 Languages Spoken

Please list all languages spoken and ability in each:……

4.0 Your Employment History

Please continue on 'Section 8.0 Your Notes' or on a separate sheet if required

Please provide in date order, details of your full employment history since leaving full time education starting with your present or latest position. Please note that to work within specialist clinical areas you will need to demonstrate that you have within the last two years gained a minimum of 1 years experience in your specialty. For this you must be able to provide the details of at least one professional reference within 'Section 5.0 Your References' Employers will not be approached without your permission. Please account for any intervals of non-employment and include temporary jobs and full time service.

Name & full address:	Dates: From:	Type of ward/dept: No of beds	Salary:

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	To:	/employees:	
	Position Held:		Reason for leaving:

Duties/Responsibilities – Please give FULL DETAILS. Continue on Your notes if necessary.

Name & full address:	Dates: From: To:	Type of ward/dept: No of beds /employees:	Salary:
	Position Held:		Reason for leaving:

Duties/Responsibilities – Please give FULL DETAILS. Continue on Your notes if necessary.

Name & full address:	Dates: From: To:	Type of ward/dept: No of beds /employees:	Salary:
	Position Held:		Reason for leaving:

Duties/Responsibilities – Please give FULL DETAILS. Continue on Your notes if necessary.

Name & full address:	Dates: From: To:	Type of ward/dept: No of beds /employees:	Salary:
	Position Held:		Reason for leaving:

Duties/Responsibilities – Please give FULL DETAILS. Continue on Your notes if necessary.

Education

Name & Address of School/College/Hospital attended	From	To	Qualifications obtained
	mm/yyyy	mm/yyyy	
	mm/yyyy	mm/yyyy	
	mm/yyyy	mm/yyyy	
	mm/yyyy	mm/yyyy	

	mm/yyyy	mm/yyyy	kcarenursingagency
Other Professional Courses Taken	From	To	Qualifications obtained
	mm/yyyy	mm/yyyy	
	mm/yyyy	mm/yyyy	
	mm/yyyy	mm/yyyy	

*TO BE FILLED OUT BY HOME CARE APPLICANTS ONLY

Why are you interested in domiciliary care work	
Please tell us about any relevant qualifications you have related to care work.	
Please tell us about any relevant care experience you have.	

5.0 Your References

Please give the details of at least two referees. Additional referees can be provided in 'Section 8.0 Your Notes' or on a separate sheet if required

Present or most recent employer	**Previous employer referee**
Full Name:	Full Name:
Occupation:	Occupation:
Address:	Address:

Tel Number:	Tel Number
Fax Number:	Fax Number:
Email:	Email:

Can we fax or email your referees to speed up the registration process? ☐ Yes ☐ No

Can we approach your referees before the interview? ☐ Yes ☐ No

6.0 Preferences and Interests Questionnaire

Can you cook	☐ Yes ☐ No
Are you a vegetarian	☐ Yes ☐ No
If yes are you prepared to cook meat?	☐ Yes ☐ No
Are you prepared to look after pets?	☐ Yes ☐ No
Are you a smoker	☐ Yes ☐ No
If no are you prepared to look after a client who does smoke?	☐ Yes ☐ No
Leisure interests/activities (please include details of any community or voluntary experience)	
Public duties (e.g. Justice of the Peace, local councillor, school governor, prison visitor, etc.)	

7.0 Health Questionnaire

Please answer the questions below by placing a tick in the appropriate column. If your answer is Yes, please give details in the space provided or continue on a separate sheet, if necessary.

	Yes	No	Details with Dates
Do you consider yourself to be in good health?			
Have you had any health issues identified during an assessment in any Occupational Health Department?			
If Yes, were you passed fit without any medical restrictions imposed on your conditions of work?			

Have you ever been retired on medical grounds or had to give up work due to ill health or injury?			
Do you consider yourself to be disabled? (The Disability Discrimination Act 1995 defines disability as: a physical or mental impairment which has a substantial and long term adverse effect on the ability to carry out normal day to day activities.)			
Have you had more than 2 weeks sick leave continuously over the past two years? (Please state reason for absence and duration of absence)			
Are you currently suffering from medical or surgical condition for which you are receiving treatment and/or awaiting a medical/surgical appointment? (Treatment includes physiotherapy, psychotherapy counselling, etc. If on prescribed medication, please give details.			
Over the last 5 years have you had any medical/surgical conditions (excluding maternity leave) which have required treatment for longer than 1 month?			
Do you currently have a medical condition for which you have not sought the help of a health professional?			
Have you ever suffered from mental health illness, anxiety, depression or other psychiatric disorder, such as nervous breakdown?			
Have you ever had a drug or alcohol problem?			
Do you have any speech, hearing or visual difficulties?			
Have you been screened for MRSA within the last 6 months?			
Do you intend to work night duties on a regular basic?			
Do you smoke? If yes please give daily amount.			
	Yes	**No**	**Details with Dates**
How many unit of alcohol do you drink per week? One unit = half pint beer, or 1 glass wine or 1 shot of spirit			
Are you pregnant? This question is asked to ensure only that any health needs of pregnancy are addressed, and to avoid any hazard or risk to a developing baby.			
If you have ever suffered from the following ailments/illnesses please give details of the dates, duration and outcomes in the space provided;			

Asthma, bronchitis or chest complaints			
Chest pain, heart condition or raised blood pressure			
Blackouts, epilepsy, fits or attacks of giddiness			
Rheumatism or arthritis			
Back or neck problem			
Typhoid, paratyphoid or dysentery			
Digestive or bowel disorder			
Diabetes, thyroid or other gland problems			
Bladder or kidney problems			
Dermatitis or other skin problems.(such as psoriasis)			
Varicose veins or DVT			
Please use this space to provide any medical information about you, which you think could affect your ability to work within the health and social services environment, and for which you may require support:			

7.1 Record Of Immunity

Have you been immunised against the following? If Yes, please give the date in the space in the space provided. Please answer the questions below by placing a tick in the appropriate column.

	Yes	No	Date
Triple vaccine (Diphtheria, Whooping Cough, Tetanus)			
Tetanus			
Polio			
Rubella (German Measles)			
Varicella (Chickenpox)			

Tuberculosis			
BCG (TB Vaccination)			
Have you ever been treated for TB?			
Have you had a chest X-ray in the last 2 years?			Result:
Hepatitis A			Result:
Hepatitis B			Result:

(please provide evidence of the blood test result demonstrating Hep B titre levels):
Date 1: Date 2: Date 3:

If you have answered "No" to Hepatitis B, are you in the process of undertaking a course of immunization?

If accepted to work within the health care industry, you are required to ensure that any changes to the information given in this questionnaire or changes to your medical condition are declared.

7.2 Notice:

All applicants are reminded that it is unethical for Health Care Workers who know or believe themselves to be infected with any blood borne viruses (HIV, Hepatitis B or C) or other communicable diseases (e.g. Tuberculoses) to put patients at risk by failing to seek appropriate counselling or by failing to disclose it when notified. Such behaviour may affect your ability to practise within the healthcare industry.

7.3 Health Declaration

I certify that the answers to the questions are correct and that the information provided is true, accurate and complete.

I understand that I may be required to undergo a medical examination if necessary.

I understand that no medical details will be disclosed without my permission to any individual other than those necessary and authorised within either the Regional Health Authority or Kcare Nursing Agency Ltd.

I understand that failure to disclose information or the giving of false information may prohibit an offer of temporary staffing assignments.

Print Name …….

Signature …… Date ……

8.0 Your Notes

Please include any additional information that may be relevant to your application and has not already been mentioned in any other part of the form;

……
……
……
……
……
……
……
……
……
……

9.0 Declaration

I declare that the information I have given in this application form is complete and accurate in all respects.

I understand that Kcare Nursing Agency needs to process the information that I have provided to them which constitutes personal and sensitive data as defined in the Data Protection Act 1998.

I hereby give my consent for Kcare Nursing Agency to process such data for the purpose of Health and Safety and to other parties as required to assess whether I am suitable for flexible staffing assignments.

I also understand that knowingly giving false information will disqualify me from registration with Kcare Nursing Agency.

Signed: _____

Date: _____

KCARE INFORMATION CHECKLIST- FOR OFFICIAL USE ONLY

NMC Statement of Entry Document Seen ☐ Photocopy ☐

Verbal Check – Date …… Written Check – Date …….. Signature ……

PIN Card ☐ Document Seen ☐ Photocopy

National Insurance Card ☐ Document Seen ☐ Photocopy

Visa/ Work Permit	☐ Document Seen	☐ Photocopy
Passport	☐ Document Seen	☐ Photocopy
Manual Handling	☐ Document Seen	☐ Photocopy
Other Certificates	☐ Document Seen	☐ Photocopy
Hepatitis B	☐ Document Seen	☐ Photocopy

Titre Levels ……..

Reference 1	Date sent …….....	Received …….....	☐ Accept	☐ Reject
Reference 2	Date sent …….....	Received …….....	☐ Accept	☐ Reject
Reference 3	Date sent …….....	Received …….....	☐ Accept	☐ Reject

CRB Disclosure Application:
Date sent to Central Support …….. Form Ref:…… Disclosure Number ……..

Proof of Identity – Originals checked, tick box and attach photocopies, signed "originals seen"

☐ Passport ☐ Driving License (photo card type) ☐ Recent Utility Bill

☐ Birth Certificate ☐ Marriage Certificate ☐ Paper Driving License

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P45 / 46 ☐ Completed Bank Details Form ☐ Completed

Night Assessment offered ☐ Accepted ☐ Declined

Written & Verbal Knowledge of English ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

Terms and Conditions ☐ Signed ☐ Photocopy

ID Badge Given ☐ Completed ☐ Expiry Date

Declaration of Health From GP ☐ Yes ☐ No ☐ Seen

Opt out agreement ☐ ☐ ☐

Annual update required Date ……

Starter Form ☐ Completed – Date sent to Payroll …… Consultants Signature ……...

Member ☐ Accepted ☐ Rejected Reasons …… ……..

Consultants Signature _____ Date _____

10.0 Equal Opportunities Monitoring Form

kcarenursingagency

Kcare Nursing Agency 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 Nursing Agency 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 Nursing Agency'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/work base: ……..

Date of birth: ……

Female ☐ Male ☐

Where did you see this post advertised? ……

How would you describe your ethnic origin? (please tick the appropriate box - using new recommended categorisation). 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? No/Yes
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

For official use only: