

Your Personal Details

Position registering for: _____	NMC PIN: _____	PIN expiry date: _____	Referred by: _____
Surname: _____	Title (Mr/Mrs/Ms/Miss/Dr ect): _____		
Forename(s): _____	Date of birth: _____		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: _____		
Nationality: _____	Religion: _____		
NI number: _____	Next of kin: _____		
Address: _____	Relationship: _____		
_____ Postcode: _____	Next of kin address: _____		
Home tel: _____	NOK contact no: _____		
Mobile no: _____	Your e-mail: _____		
Union Membership <input type="checkbox"/> yes <input type="checkbox"/> no			
Drivers license <input type="checkbox"/> yes <input type="checkbox"/> no	Do you have the use of a car <input type="checkbox"/> yes <input type="checkbox"/> no		

Work preferences

<input type="checkbox"/> A & E	<input type="checkbox"/> ENT	<input type="checkbox"/> Neurology	<input type="checkbox"/> Recovery
<input type="checkbox"/> Anesthetics	<input type="checkbox"/> Genito Urinary	<input type="checkbox"/> Oncology	<input type="checkbox"/> Renal Dialysis
<input type="checkbox"/> Burns & Plastics	<input type="checkbox"/> Geriatrics	<input type="checkbox"/> Ophthalmic	<input type="checkbox"/> Surgical
<input type="checkbox"/> Cardio Thoracic	<input type="checkbox"/> Gynae	<input type="checkbox"/> Orthopedic	<input type="checkbox"/> Terminal Care
<input type="checkbox"/> CCU	<input type="checkbox"/> Hematology	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Theatres
<input type="checkbox"/> Dermatology	<input type="checkbox"/> ITU / ICU	<input type="checkbox"/> Pediatrics ICU	<input type="checkbox"/> Nursing homes
<input type="checkbox"/> Disability	<input type="checkbox"/> Learning Difficulties	<input type="checkbox"/> Psychiatry	<input type="checkbox"/> Home Care

Competencies (Healthcare Assistants)

<input type="checkbox"/> BP / Pulse / Temp / Respiration	<input type="checkbox"/> Fluid / feed charts	<input type="checkbox"/> Catheter Care & Urinalysis	<input type="checkbox"/> Mouth Care
<input type="checkbox"/> Pressure area care	<input type="checkbox"/> Safe use of patient hoist		

Entitlement to work *(please submit supporting documentation)*

<input type="checkbox"/> UK passport	<input type="checkbox"/> Permanent Residency	<input type="checkbox"/> Student Visa	<input type="checkbox"/> Other immigration status _____
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Your banking details

Bank/Building Society Name: _____	Account Name: _____	
Address of Bank/Building Society: _____		
Account Number: _____	Sort Code: _____ - _____ - _____	Building Society Ref No.: _____

Employment history

Position and Dates	Name and Address of Employer	Reason for leaving

Professional Qualification

Qualification	Training Establishment	Dates

Training *(Please provide originals or verified copies of training certificates)*

Have you completed a course in the following?			
Moving and Handling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Health and Safety	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Fire Safety	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
POVA	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Infection Control	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Basic Life Support	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Dementia Awareness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Basic Food Hygiene	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Any other training	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
If yes, please provide relevant certificates			

References

Please provide the names and addresses of two referees, including your most recent employer. Both referees must be in a position to assess your clinical skills.

Referee 1

Name: _____

Position: _____

Address: _____

Tel No: _____ Ext: _____

Fax: _____

E-mail: _____

Referee 2

Name: _____

Position: _____

Address: _____

Tel No: _____ Ext: _____

Fax: _____

E-mail: _____

Your Health Record

- | | | |
|---|------------------------------|-----------------------------|
| 1. Are you currently or regularly taking any medicines, tablets, injections or special diets? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Are you attending any hospital for treatment or are you on a waiting list for hospital treatment? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Is there any aspect of your medical history which an employer should or might wish to know | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Do you have any conditions of vision, hearing or speech which might affect your ability to work? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Is there any aspect of your health which may restrict your ability to work? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Would you require any adjustments to a working environment to work? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you now or have you ever suffered from or received treatment for: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| a. Bone or joint symptoms, disorders or diseases (including back pain)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. Cardiovascular symptoms, disorders or diseases? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. Endocrine (including diabetic) symptoms, disorders or diseases? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Gastrointestinal symptoms, disorders or diseases? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. Genitourinary symptoms, disorders or diseases? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e. Haematological symptoms, disorders or diseases? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Immuno-deficiency symptoms, disorders or diseases? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f. Neurological (including epileptic) symptoms, disorders or diseases? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Respiratory (including asthmatic or allergic) symptoms, disorders or diseases? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g. Skin symptoms, disorders or diseases including reaction to gloves/glove powder? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| h. Depression, stress related symptoms or other psychiatric disorders or diseases? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| i. Alcohol or drug misuse? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| j. Alcohol/ drug related symptoms, disorders or diseases (including adverse reactions to any drug/ medication)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If you have answered YES to any of the above questions please give additional information on a separate sheet including dates and treatment.

Immunization History *(Please ensure you attach relevant proof of vaccinations and test results)*

	YES	NO	DATE
BCG	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heaf/ Tine/ Mantoux test	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polio	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Varicella	<input type="checkbox"/>	<input type="checkbox"/>	_____
MMR	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	_____
Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis C check	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis B - Initial course	<input type="checkbox"/>	<input type="checkbox"/>	_____
Last booster	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hep B Surface Antigen	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please provide us with a copy of your latest Hepatitis B status (can be obtained from your current employer or approach your GP)

Data Protection

Smart Recruitment Ltd is registered with the Data Protection Commissioner as a "Data Controller" within the terms of the Data Protection Act 1998 for the purposes of the collection, storage and use of personal data for the purposes set out below. Personal information provided by you ("Your Data") is collected and used within the provisions of the Data Protection Act 1998. Personal data that is exempt from notification under the Data Protection Act 1998 is also processed. The foregoing companies will be Data Controllers in respect of Your Data. If you would like to know what personal information relating to you is being held by us then please send a written request to The Data Controller, Smart Recruitment Ltd, 99 Clifton Road, Worthing, BN11 4DP together with payment of £10 asking for a description of the personal data held.

Professional Conduct

Rehabilitation of Offenders Act 1974 (All applicants)

Have you ever been convicted of a criminal offence, been bound over or cautioned or are you currently the subject of any police investigations, which might lead to a conviction, an order binding you over or a caution in the UK or any other country? Yes No

I the signatory undertake to inform you of any thing which occurs in the future which may result in a prosecution.

Please sign and date Signed: Date:

Declaration

I declare that the statements on this form are true and complete to the best of my knowledge and belief and I am aware that any false statements may affect my application. I will immediately notify Smart Nursing Agency™ of any changes to statements made on this form. From time to time, Smart Nursing Agency™ will be audited by authorised third parties to ensure compliance with legislation. I permit Smart Nursing Agency to allow my file to be viewed by authorized third parties for auditing purposes.

Signed: Date: