Ref No.____

Office:_____

Please affix photograph here

The other copy to be used for ID

Office No. 5, Business Hub, Pandora House,
41-45 Lind Road, Sutton, Surrey , SM1 4PP
Telephone: 020 3489 8088; Mobile No: 079 3270 6983
Email: **info@jernnhealthcare.co.uk**
Web: **www.jernnhealthcare.co.uk**

Please return form to Your Local Branch Office
Application details accepted in our database ONLY after a face to face recruitment interview

APPLICATION FOR EMPLOYMENT

Profile/Grade _____ (Nurse, HCA, Trainer etc) Date _____

1. PERSONAL DETAILS

TITLE.....

ADDRESS .....

.....

.....

.....

POSTCODE .....

TEL HOME .....

MOBILE .....

EMAIL .....

FAX .....

SURNAME.....

OTHER NAMES.....

DATE OF BIRTH .....

NATIONAL INSURANCE NO. .....

NATIONALITY .....

DRIVER YES/NO

REQUIRE WORK PERMIT? YES/NO

IF YES, EXPIRY DATE:.....

Explain type of permit: .....

NEXT OF KIN .....

NEXT OF KIN ADDRESS .....

NEXT OF KIN TEL NO .....

NEXT OF KIN MOBILE NO .....

NEXT OF KIN EMAIL .....

RELATIONSHIP TO NEXT OF KIN .....

QUALIFIED NURSES AND SOCIAL WORKERS ONLY:

NMC PIN/REGISTRATION NO. .....

DATE FIRST ENTERED ON REGISTER: .....

WHICH PARTS OF THE REGISTER?.....

EXPIRY/RENEWAL DATE .....

PROVIDERS AND PROFESSIONAL INDEMNITY INSURANCE NO. .....

2. ACCESS (NI) CHECKS

APPLICATION REF: | DATE CRB APPLIED | DATE RECEIVED:

3. BANK DETAILS

NAME OF BANK .....

BANK ADDRESS .....

.....

NAME OF ACCOUNT .....

SORT CODE .....

ACCOUNT NO. .....

REF .....

4. QUALIFICATIONS

(Qualified Nurses Must also provide documentary details of their professional registration with NMC which will be placed in their personnel file)

	DATE	QUALIFICATION	COURSE TITLE	INSTITUTION	GRADE ATTAINED
1.					
2.					
3.					
4.					
5.					
6.					

MANDATORY A N D INDUCTION TRAINING (This applies to all Healthcare workers):	DATE TRAINED	EXPIRY DATE
FIRE SAFETY AND PROCEDURES		
MOVING and HANDLING		
FIRST AID AWARENESS		
HEALTH& SAFETY		
INFECTION CONTROL		
SAFE HANDLING OF MEDICATION		
DEMENTIA AWARENESS		
FOOD HYGIENE		
SAFEGUARDING VULNERABLE ADULTS		

5. PROFESSIONAL MEMBERSHIPS

	DATE ADMITTED	NAME OF BODY	DETAILS OF MEMBERSHIP	LEVEL
1.				
2.				
3.				
4.				
5.				

Note that it is your responsibility to inform Jernn Health when you are suspended /removed from list or under investigation from that professional body.

6. WORK HISTORY/EXPERIENCE AND REFERENCES - Mandatory

(Note this is also authority for us to ask for references from your most recent employer. We need you to complete a minimal continuous 5 years history. If not worked at some time in this period, please provide explanation for any gaps. We need at least 2 references, one from your previous employer.)

Date from-to	Employer's Name	Address	Contact	Title

Please also provide details of a work colleague who will give us your character reference.

NAMES:	ADDRESS:
TELEPHONE	
EMAIL:	
Give details of any major medical condition or continuous medication:	

7. WORK PREFERENCES

Please use this space to tell us if you have any work preferences-shifts, location etc.

Is there anything you would wish to add not covered above?.

8.FITNESS TO WORK CERTIFICATE - *this is optional but some employers may prefer it completed*

A copy of this questionnaire has to be presented to your GP, a local NHS Trust or a qualified occupation Health Practitioner. Ask for a fresh copy if you do not intend to take this one to the practitioner.with your certificates of Immunisation, they will be able to certify that you are fit to work in the position you have applied for.

Surname:	Other Names:
Gender: Male / Female	Date of Birth:
Nationality:	Position Applied:

Exposure Levels - Please mark areas below that you believe are applicable to position you applied

Exposure to chemicals	Yes	No	Driving	Yes	No
Working in Confined space	Yes	No	Contact with Client for Personal Care	Yes	No
Night work	Yes	No	Exposure to Blood or body fluids	Yes	No
Shift rotation	Yes	No	Moving, Lifting & Handling of Client	Yes	No
Radiation	Yes	No	Moving, Lifting & Handling of other objects	Yes	No
Pharmacy	Yes	No	Exposure Prone Invasive Procedures (EPIP)	Yes	No
Substantial access to children	Yes	No	Food Handling	Yes	No
Visual Display screen user (continuously more than 1 hr/day)	Yes	No	Working at Heights	Yes	No

If you have ever felt that working at night is harmful to your health, please state here:

If you have felt that you have a medical condition that may affect your working at night, please state here:

How may days have you lost from work in the past year?

Please state what was this loss due to:

MEDICAL HISTORY: Please answer ALL questions

DO YOU, OR HAVE YOU EVER SUFFERED FROM? (if yes, please give details):

Any impairment that may affect your ability to work or perform duties safely?	YES/NO	
Eyesight problems not corrected by Glasses /contact lenses?	YES/NO	
Difficulties in Walking, bending, lifting or any other movement?	YES/NO	
Difficulties in hearing not correctable by hearing aid?	YES/NO	
Muscular-skeletal problems, including Arthritis or a back problem?	YES/NO	
Significant discomfort when using a keyboard?	YES/NO	
Psychological conditions including stress at work?	YES/NO	
Fits/blackouts or epilepsy?	YES/NO	
Suffered any accidents that significantly affected you physically or mentally?	YES/NO	
Suffered from Asthma, Bronchitis or serious chest problems?	YES/NO	

Treated for Tuberculosis?	YES/NO	
Gastrointestinal problems including Hepatitis?	YES/NO	
Diabetes, Thyroid or endocrine problems	YES/NO	
Cardio-vascular problems including hypertension or a blood disorder?	YES/NO	
Dysentery, Typhoid, Paratyphoid ,food poisoning, salmonella, severe gastroenteritis or diarrhoea?	YES/NO	
Had an operation in the past 2 years?	YES/NO	
If you are under any medication (please give name of drug and dosage)	YES/NO	
Are you waiting for any medical treatment, investigation or test at the moment?	YES/NO	
Have you ever suffered from any serious/frequent headaches or episodes of migraine?	YES/NO	
Do you think you had any illness that was made worse by your work?	YES/NO	
Have you ever had any drug or alcohol problem?	YES/NO	
Do you consider yourself as having any disability?	YES/NO	
Have ever had any concern/fear that you may have a health problem?	YES/NO	
Coughs/Vomiting/diarrhoea/Rash-In the last 12 months, have you had a cough for more than 3 months, ever	YES/NO	
coughed/Vomiting/diarrhoea/Rash blood or any unexplained loss of weight or fever?	YES/NO	

Allergies-state here if any:

Do you have any more relevant medical information you think is not covered above? If yes, please state here or continue on a separate sheet of paper:

9. SELF DECLARATION BY APPLICANT

1 .I declare that the information provided on this questionnaire is true to the best of my knowledge and accept that it will form the basis upon which the

Qualified medical practitioner will base the certification as to my fitness to work for the position applied for.

2. I also state that I will inform Jernn Health Ltd of any changes that may occur that may affect my ability to work for the position applied for.

3. I understand that it is my responsibility to ensure that all information provided is based on my truthfulness and that if I fail to notify Jernn Health of any changes that may occur at any time, Jernn Health Ltd may at their choice cease placing me for job vacancies

4 .I accept that my personal details will be safely stored and handled by Jernn Health Ltd in accordance with the Data protection Act 1998, and that the same may be made available for Audit/Review by relevant organization like NHS PASA, CQC and where by law necessary the company's service users.

5.I understand that I am required to declare when unfit (including when suffering from Vomiting , Diarrhoea or a rash before accepting any placement

6. I also understand that all Female workers must declare when they become Pregnant

7. I understand where the client books me direct and bypassing Jernn Health, such work may not be paid or/and match options takes no responsibility

8.I understand that a Service user may require me to undergo a medical check-up before commencement of an assignment

9. I confirm that I have been made aware and been issued with Jernn Health sheets on: AIDS/HIV, (HSC 1998/226),MRSA,Varicella, Clostridium Difficile, POVA, Prevention of abuse of children and that I will undertake necessary training when asked by the company

10. I confirm that I have received a Job Description Specification and a contract for Employment which enabled me to complete the above Questionnaire for the part relating to Exposure levels.

11.I was made aware of the Equality Act 2010, and that I am satisfied with the details asked from me and the way I have supplied same in good faith

DECLARATION

12. a) declaration of offenders Act 1974-You are not entitled to withhold information regarded as "spent' under the act. This is due to the nature of work of the post which may be exempt from sec.4(2).
Any information which you give will be treated in strict confidence and in accordance with the data protection Act, which Jernn Health adheres and complies with.
Have you ever been convicted of a criminal offence, currently suspended, on notice of dismissal from employment or under investigation from any employer? YES / NO
If "YES", please provide details of all convictions and cautions, including those considered "spent"

b) By signing this application form, you also declare that to the best of your knowledge:
i) All information is my full disclosure including that which might be omitted by the DBS/ POVA check.
ii) I will inform Jernn Health any time that I am not of good health and not fit before starting for any work placement offered.
iii) I will inform the company whenever there are changes in my personal details listed on this form
iv) I have been made aware of my responsibility to prevent myself from infectious environments and among others issued with handouts covered at clause 4 above, POVA, MRSA, Clostridium Difficile, HSC 1998/226 on AIDS/HIV, Protection of Children, Health & Safety and Manual Handling issued with a contract of employment, Staff handbook in which I was made aware of the company policies and procedures con- obtained therein and not limited to Complaints, grievances and disciplinary, general conduct, WTR, Time-sheets and payroll issues including working time regulations etc
v) To comply with the Mandatory Training, performance appraisal procedures in place from time to time
vi) That Jernn Health has the right to withhold payment against revenue lost due to my negligence and non coverage of placements per contract of employment.
vii) I authorise Jernn Health to disclose, if requested, any personal data to CQC or any authorised third party e.g. police, safeguarding teams as permitted by law and that I will immediately inform the company should I receive any police cautions, reprimands or convictions while under this employment.

Name: _____ Sign and Date _____

TO BE COMPLETED BY THE PROFESSIONAL PRACTITIONER AS A CERTIFICATE

This is to certify that based on above questionnaire and certificates/records of immunisation produced, and relevant to the position applied, I consider applicant fit to work.

Tick certificates seen or any pathological tests done here-

Hepatitis B	Hepatitis C	Varicella	Rubella	TB	other(State)_____
☐	☐	☐	☐	☐	☐

Names:

Signature:

Qualifications:

Date:

Any comments:

Please insert Company stamp and address here