

20A-30 Abington Street, Northampton, NN1 2AJ

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# CANDIDATE REGISTRATION FORM

PERSONAL DETAILS

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| Please write in BLOCK CAPITALS and in black ink. | | | | | | | |
| ABOUT YOU | | | | | | | |
| Surname: | |  | | Title (Mr/Mrs/Miss/Ms) : | |  | |
| First Name(s) : | |  | | Other Name(s): | |  | |
| Marital Status: |  | | Gender: | Male Female | Date of Birth: | |  |
| National Insurance No: | |  | |  | |  | |
| Current Address: | |  | | | | | |
| Post Code: | |  | | | | | |
| Mobile Phone: | |  | | Home Phone: | |  | |
| Do you have a driving licence? | | Yes No | | Do you have use of a car? | | Yes No | |

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| ABOUT THE JOB | | | | | |
| Job Title: |  |  |  |  |  |
| Speciality 1: |  | Speciality 2: |  | Speciality 3: |  |
| Current Place of Work: |  | | Full Time Part Time  Days Nights | | |

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| PAYMENT DETAILS | | | | |
| Name of Bank/Building Society: |  |  |  |  |
| Account Name: |  | | Personal LTD | |
| Branch Address: |  | | | |
| Post Code: |  | | | |
| Account No: |  | | Sort Code: |  |

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| NEXT OF KIN | | | |
| Name of Next of Kin: |  | Relationship: |  |
| Telephone: |  |  |  |
| Address |  | | |

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| YOUR TRAINING, QUALIFICATIONS, APPRAISALS AND REFERENCES |

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| Please enclose, with your application a copy of your registration and membership card | | | | | | |
| Nurses | NMC Number: |  | RCN Number: |  | Band: |  |
| ODPS | HPC Number: |  | This does not apply to HCA’s | | | |

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| MANDATORY TRAINING | | | | | | | |
| *Please tick if you have completed the following training within the last 12 months*  *Please enclose copies of your training certificates* | | | | | | | |
| Moving and Handling: |  | Basic Life Support: |  | Intermediate Life Support: |  | Advanced Life Support: |  |
| Complaints Handling: |  | Handling Violence and  Aggression: |  | Fire Safety: |  | COSHH: |  |
| RIDDOR: |  | Caldicott Protocols: |  | Data Protection: |  | Infection Control: |  |
| Lone Worker Training: |  | Food Hygiene (where  required to handle food): |  | Personal Safety (Mental  Health &Learning Dis’): |  | Resuscitation of the  Newborn (Midwifery): |  |
| Interpretation of Cardiotocograph Traces (Midwifery): | | |  |  | | | |

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| APPRAISALS | | | | |
| In order to work in the NHS you will need to be appraised annually by a Senior Practitioner of the same discipline, this person will become your “appraiser” Please give details below of the Senior Practitioner who you have made arrangements with to act as your appraiser. | | | | |
| Please give the date of your last appraisal: | |  | | |
| Name of Appraiser: |  | Position and Grade of Appraiser: | |  |
| Branch Address: |  | | | |
| Post Code: |  | | | |
| Phone Number: |  | E-mail: |  | |

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| REFERENCES | | | |
| Please supply us with two professional referees. One must be from your present or most recent employer and must be a senior grade to yourself and you must have worked for that person for a period of not less than three months duration. | | | |
| 1. Reference Name: |  | Position: |  |
| Work Address: |  | | |
| Postcode: |  | | |
| Email: |  | | |
| Telephone: |  | Fax: |  |
|  | | | |
| 2. Reference Name: |  | Position: |  |
| Work Address: |  | | |
| Postcode: |  | | |
| Email: |  | | |
| Telephone: |  | Fax: |  |

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| |  | | --- | | YOUR TRAINING, QUALIFICATIONS, APPRAISALS AND REFERENCES |  |  | | --- | | Please enclose, with your application a copy of your registration and membership card | | | | |
| Current DBS Disclosure (formally known as CRB): | Yes No | Clear: | Yes No |
| Issue Date: |  | Disclosure Number: |  |
| Is this certificate registered with the update service? | | Yes No |  |
| *You will be requested to carry out a DBS at registration and annually upon employment* | | | |

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| IMMUNISATIONS | | | | | | | | |
| Please indicate which off the following Immunisations you have been vaccinated against and include your vaccination reports when returning your registration. | | | | | | | | |
| EPP and Non EPP | **Hep B**  Yes  No | | **TB**  Yes  No | **Varicella**  Yes  No | | **Measles**  Yes  No | | **Rubella**  Yes  No |
| EPP Candidates Only | **Hep C**  No Proof  Negative  Positive | | **Hep B Antigen**  No Proof  Negative  Positive | | | **HIV**  No Proof  Negative  Positive | | |
| All applications who cannot provide a registered DBS or full immunisation record will be required to complete at their own cost. Harcourt Health Hub Providers will cover the cost of any Mandatory Training updates however cancellations outside of 48 hours and late attendances will be charged to the candidate. Candidates will be required to purchase uniform if required at the cost of £20 this will be deducted from your timesheet once you have started working through us | | | | | | | | |
| Please sign to say you have read and understood the above | | | | | | | | |
| Your Signature: | |  | | | Date: | |  | |

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| |  | | --- | | WORK HISTORY |  |  | | --- | | Please ensure you complete this section even if you have a CV. The NHS states that “Employment history should be recorded on an Application Form which is signed” Please ensure that you leave no gaps unaccounted for and it covers 10 years or up to your education. | |
| Covers 10 years work history or as far back as your education  Dates to and from are shown in a mm/yy format  Dates are continual with NO gaps  Where there have been gaps in work history please state the reason for the gaps  Lists all relevant training undertaken |

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| From: |  | To: |  | Name of Employer: |  |
| Job Title: | |  | | Grade: |  |
| Address: | |  | | Main Responsibilities: |  |
| Reason for Leaving: | |  | | | |

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| From: |  | To: |  | Name of Employer: |  |
| Job Title: | |  | | Grade: |  |
| Address: | |  | | Main Responsibilities: |  |
| Reason for Leaving: | |  | | | |

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| From: |  | To: |  | Name of Employer: |  |
| Job Title: | |  | | Grade: |  |
| Address: | |  | | Main Responsibilities: |  |
| Reason for Leaving: | |  | | | |

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| From: |  | To: |  | Name of Employer: |  |
| Job Title: | |  | | Grade: |  |
| Address: | |  | | Main Responsibilities: |  |
| Reason for Leaving: | |  | | | |

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| DECLARATIONS | | | | | |
| HEALTH DECLARATIONS | | | | | |
| All applicants must complete the enclosed health questionnaire to enable us to establish your fitness for work. We would ask all  OVERSEAS candidates to provide a medical statement from their GP or medical department confirming your state of health. Your details will be passed to our Occupational Health Doctors to establish your fitness for work. Please sign the declaration below to allow Harcourt Health Hub /Care Providers Recruitment to release your information for inspection.  I …………………………………………………………………………………………………………………. consent to Harcourt Health Hub/Care Providers Recruitment releasing my health and immunisation records for review to Harcourt Health Hub qualified Occupational Health Advisor. I understand that based on this review I may be required to undergo a medical examination to establish my fitness for work.  I confirm that I will immediately inform Harcourt Health Hub /Care Providers Recruitment in confidence if I am HIV Positive, HepB positive or if I have AIDS in accordance with the Department of Health guidelines. I am aware of my obligations regarding MRSA contact and the need for screening. I agree to immediately inform Harcourt Health Hub /Care Providers Recruitment should my general condition of health change.  I will inform Harcourt Health Hub /Care Providers Recruitment immediately if I discover that I am pregnant. I understand that withholding information or giving false answers may lead to dismissal. I also hereby consent to Harcourt Health Hub /Care Providers Recruitment obtaining further information regarding my health from my GP or Occupational Health Department. | | | | | |
| Signed: |  | Print Name: |  | Date: |  |

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| PERSONAL DECLARATIONS | | | | | |
| I hereby confirm that the information provided on my application is correct and true to the best of my knowledge and that I have not withheld any information that should be taken into account when offering me work.  I understand that providing false or inaccurate information may result in the termination of any placement. I agree that I will make best endeavours to make myself aware of the Health & Safety procedures for each client I am assigned to.  I confirm that I have read and understood the Terms of Engagement and the terms of the declaration and agree to be bound by them. | | | | | |
| Signed: |  | Print Name: |  | Date: |  |

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| WORKING TIME REGULATIONS DECLARATIONS | | | | | |
| For the purposes of the Working Time Regulations 1998 (as amended) I, consent to work in excess of an average of 48 hours per week, averaged over 17 weeks. I understand that I may withdraw this consent by giving Harcourt Health Hub /Care Providers Recruitment not less than three months’ notice at any time. | | | | | |
| Signed: |  | Print Name: |  | Date: |  |

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| OTHER DECLARATIONS | | | | | |
| In addition, I also consent to work in excess of the maximum number of hours permitted to work at night under the directive. Please note you are under no obligation to sign either declaration. | | | | | |
| Signed: |  | Print Name: |  | Date: |  |

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| CONFIDENTIALITY | | | | | |
| I hereby declare that at no time will I divulge to any person, nor use for my own or any other person’s benefit, any confidential information in relation to the Client or the Company (Harcourt Health Hub /Care Providers Recruitment) or in relation to any of their employees, business affairs, transactions or finances which I may acquire during the term of my agreement with the Company (Harcourt Health Hub) under the Terms of Engagement. | | | | | |
| Signed: |  | Print Name: |  | Date: |  |

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| REHABILITATION OF OFFENDERS ACT 1974 – Please answer all five questions | | | | | |
| Because of the nature of the work for which you are applying , Section 4(2), and further Orders made by the Secretary of State under the provision of this section of the Rehabilitation of Offenders Act (1974) (Exceptions) Order 1975 apply. Applicants are therefore required to give information about convictions which for other purposes are “spent” under the provisions of the Act. Any information given will be completely confidential and will be considered only in relation for positions to which the order applies. | | | | | |
| 1. Do you have any convictions, cautions or bindovers?   If yes please give details... | | | | | Yes No |
| 1. Have you ever had disciplinary action taken against you?   If yes please give details... | | | | | Yes No |
| 1. Are you at present the subject of criminal charges or disciplinary action?   If yes please give details... | | | | | Yes No |
| 1. Do you consent to Harcourt Health Hub requesting a police check and any appropriate references on your behalf? | | | | | Yes No |
| 1. Have you been police checked in the last three years?   If so, by whom... | | | | | Yes No |
| Signed: |  | Print Name: |  | Date: |  |

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| RIGHT TO WORK IN THE UK | | | | | |
| Please complete this form, regardless of your nationality, as it is a legal requirement. If you are an overseas national or require a work permit to work in the UK please include copies of supporting documentation.  Your entitlement for working in the UK is based upon what status: | | | | | |
| EU Citizen: |  | Spouse of an EU Citizen: |  | Work Permit: |  |
| Permit-free Visa: |  | Right of Abode in the UK: |  | Admitted to UK as Doctor Prior to 1985: |  |

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| HEALTH AND SAFETY | | | | | |
| Each agency worker has a responsibility at the start of their first shift to become familiar with the Client’s general policies including, without limitation, those relating to Crash Call Procedures, the Hot Spot Mechanism for alerting security staff that an individual is in trouble, Fire Policy and the Violent Episode Policy. | | | | | |
| Signed: |  | Print Name: |  | Date: |  |

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| REGISTRATION FORM DECLARATIONSPlease read before signing | | | | | |
| I declare that by signing this form I am stating that I am legally entitled or allowed to work in the United Kingdom, with or without necessary permission from the Home Office or any other relevant authority. If I have secured permission to work, I have included copies of all documentation. I also acknowledge that if it is found that I am working without the relevant permission, my employment will be terminated with immediate effect and all details passed to the relevant authorities.  I agree that Harcourt Health Hub /Care Providers Recruitment retains the right to hold this registration form and any other data required to process it and pass onto any authorised third party and the details held within. I also agree to use all reasonable efforts to assist to comply with the Data Protection Act 1998.  In addition, I confirm that that all the information provided is true and accurate and that I have received and agree to Harcourt Health Hub / Care Providers Recruitment terms of engagement and Staff Handbook. | | | | | |
| Signed: |  | Print Name: |  | Date: |  |

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| Please send your completed registration pack to: |
| 20A-30 Abington Street, Northampton, NN1 2AJ  Email: info@harcourthealthhub.co.uk |