

[](https://twitter.com/WimborneNA)[](https://www.linkedin.com/company/wimborne-nursing-agency)15 New Fields Business Park, 2 Stinsford Road, Poole, Dorset, BH17 0NF

[](https://web.facebook.com/WNAHMR)Tel: 01202 665550, Fax: 01202 665568

WNA Healthcare HMR Medical & Nursing

Tel Ext: Option 6 Tel Ext: Option 2

[apply@wna.healthcare](mailto:apply@wna.healthcare) [nursing@hmr.co.uk](mailto:nursing@hmr.co.uk)

[www.wna.healthcare](http://www.wna.healthcare) [www.hmr.co.uk](http://www.hmr.co.uk)

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| --- |
| **YOUR APPLICATION PACK** |

|  |  |
| --- | --- |
| **NAME** |  |
| **POSITION (RGN / RMN / HCA)** |  |
| **RECOMMENDED BY** |  |
| **REVIEWED BY** | |  | | --- | | Maria Alibhai (86E0211E) and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **SIGNED BY** | **Maria Alibhai** |

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| **PRIMARY COMPANY YOU WISH TO JOIN** |

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| **WNA** |  | **HMR** |  |

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| **DO YOU HAVE A SUBSTANTIVE CONTRACT WITHIN THE NHS** |

 

**I agree that the information I provide in this application pack can be used by both sister companies – WNA Healthcare and HMR Medical & Nursing Services. This is to provide me with more opportunity and diversification in the work I can potentially be offered.**

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| **SIGNATURE** |  | **DATE** | 31 March 2017 |

**Please use BLOCK CAPITALS where possible and return the application pack within 7 days to take advantage of our fast track application process.**

**APPLICANTDETAILS**

You will need to provide the following evidence to support your details:

* Personal Identification 
* Address 

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| **YOUR PERSONAL DETAILS** | | | | | |
| **TITLE** |  | **SURNAME** |  | | |
| **FORENAME** | |  | | | |
| **MIDDLE NAME** | |  | | | |
| **MAIDEN NAME** | |  | | | |
| **MARITAL STATUS** | |  | | **DATE OF BIRTH** |  |
| **ADDRESS** | |  | | | |
| **ADDRESS 2** | |  | | **TOWN** |  |
| **COUNTY** | |  | | **POST CODE** |  |
| **LANDLINE PHONE** | |  | | **MOBILE PHONE** |  |
| **EMAIL** | |  | | | |
| **NEXT OF KIN DETAILS** | | | | | |
| **FULL NAME** | |  | | | |
| **RELATIONSHIP** | |  | | | |
| **ADDRESS** | |  | | | |
| **ADDRESS 2** | |  | | **TOWN** |  |
| **COUNTY** | |  | | **POST CODE** |  |
| **LANDLINE PHONE** | |  | | **MOBILE PHONE** |  |
| **EMAIL** | |  | | | |

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| **NMC DETAILS** | | | |
| **NMC NUMBER** |  | **NMC EXPIRY DATE** |  |
| **NMC PART(s) OF REGISTER** |  | **NMC PART(s) EXPIRY DATE** |  |
| **PROFESSIONAL INDEMNITY INSURANCE UNION** |  | | |

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| **TRANSPORT DETAILS** | | | |
| **CAR** |  | **PUBLIC TRANSPORT** |  |

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| **OTHER (Please specify)** |  |

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| **NATIONALITY DETAILS** |

**We do not employ any nurse/carer requiring a work permit or with limited leave to remain in the UK.**

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| **NATIONALITY** |  |
| **NATIVE LANGUAGE** |  |
| **NATIONAL INSURANCE NUMBER** |  |

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| **ELIGIBILITY TO WORK IN UK**  **Tick as appropriate**  **Not applicable for UK citizen** |  | **I am eligible to work in the UK and do not require a work permit.** |
|  | **I am already in possession of a work permit to work in the UK.** |
|  | **I need to obtain a work permit to work in UK** |
|  | **Other (please specify below)** |
| **OTHER:** |  | |
| **WORK PERMIT EXPIRY DATE:** |  | |

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| **YOUR PAYE / LTD BANK ACCOUNT DETAILS** |

**Your wages are paid directly into your account. Please therefore ensure your details are correct. Incorrect or incomplete details can result in a delay in payment to you.**

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| P;  **I wish to be paid through:**  P.A.Y.E (enclose P45)  Ltd Company (private work)  WNA Umbrella  Other Umbrella  If so, provide details |

**Please provide evidence of Your/Ltd/Umbrella (whichever applies) bank account details**

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| **BANK DETAILS** | |
| **PLEASE STATE PAYE OR LTD ACCOUNT** |  |
| **ACCOUNT HOLDER NAME** |  |
| **COMPANY NAME (if applicable)** |  |
| **NAME OF BANK** |  |
| **ADDRESS** |  |
| **TOWN** |  |
| **COUNTY** |  |
| **POSTCODE** |  |
| **SORT CODE** |  |
| **ACCOUNT NUMBER** |  |

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| **YOUR EMPLOYMENT HISTORY** |

*\*\* Please provide details of your* ***FULL HISTORY*** *in* ***MM/YY*** *format starting from secondary school to date.*

*\*\* Please explain the gaps in your history. Please continue on a different sheet if required.*

*\*\* A Comprehensive* ***FULL CV*** *is acceptable provided it lists your full history from secondary school, and details the month and years.*

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| **DATE**  **FROM**  **MM/YY** | **DATE TO**  **MM/YY** | **EMPLOYER’S NAME AND ADDRESS** | **POSITION** | **REASON**  **FOR LEAVING** |
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| **YOUR PROFESSIONAL CONDUCT** |
| Have there been any proceedings of medical negligence or professional misconduct against? Yes  No  If yes please give details below  Have ever been suspended or dismissed?  Yes  No  If yes please give details below |

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| **If “YES” please supply details:** |  |

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| **REHABILITATION OF OFFENDERS ACT** |
| Due to 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 Rehabilitation of Offenders act (1974) (Exceptions) Order 1975 applies. Applicants are required to give information about convictions which for other purposes are “spent” under the provisions of the Act. Any information given will be confidential and will be considered only in relation for positions to which the order applies.  Have you at any time been convicted of an offence? Yes  No  If yes, give details |

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| **NAME :** |  | **SIGNATURE:** |  |

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| **YOUR REFERENCE DETAILS** |

*\*\* Please supply the name and work address of at least 2 professional referees.*

*\*\*One must be from your present or most recent employer and must be a senior grade to yourself.*

*\*\*2nd needs to be a previous employer unless you have been employed more than 3 years then it must be someone from your current or most recent employer.*

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| **NAME** |  | **GRADE** |  | **DOB** |  |

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| **1st Reference – Senior Clinical** | |
| **NAME** |  |
| **POSITION** |  |
| **ADDRESS** |  |
| **ADDRESS CONTINUED** |  |

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| --- | --- | --- | --- |
| **TOWN** |  | **COUNTY** |  |
| **POST CODE** |  | **EMAIL ADDRESS** |  |
| **PHONE NUMBER** |  | **FAX NUMBER** |  |
| **DATES FROM** |  | **DATES TO** |  |

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| **2nd Reference – Clinical** | |
| **NAME** |  |
| **POSITION** |  |
| **ADDRESS** |  |
| **ADDRESS CONTINUED** |  |

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| **TOWN** |  | **COUNTY** |  |
| **POST CODE** |  | **EMAIL ADDRESS** |  |
| **PHONE NUMBER** |  | **FAX NUMBER** |  |
| **DATES FROM** |  | **DATES TO** |  |

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| **3rd Reference – Clinical/Character** | |
| **NAME** |  |
| **POSITION** |  |
| **ADDRESS** |  |
| **ADDRESS CONTINUED** |  |

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| **TOWN** |  | **COUNTY** |  |
| **POST CODE** |  | **EMAIL ADDRESS** |  |
| **PHONE NUMBER** |  | **FAX NUMBER** |  |
| **DATES FROM** |  | **DATES TO** |  |

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| **YOUR CLINICAL EXPERIENCE** |

*Place an “X” in the relevant experience/ years you have in each field, or* leave blank if not applicable*.*

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| **Experiences** | **0-12 months** | **1 year +** | **Experiences** | **0-12 months** | **1 year +** |
| A + E – Accident & Emergency |  |  | Neonatal |  |  |
| Anaesthetics |  |  | Neurology, Rheumatology/Head |  |  |
| Burns |  |  | NICU |  |  |
| Cannulation |  |  | Nurse Practitioner |  |  |
| Cardiac |  |  | Nursing Homes |  |  |
| CCU – Coronary Care Unit |  |  | Obstetrics |  |  |
| Chemotherapy |  |  | Occupational Health |  |  |
| Child Respite Care |  |  | ODP – Operating Department |  |  |
| Clinics |  |  | Oncology |  |  |
| Community |  |  | Ophthalmology |  |  |
| Dementia |  |  | Orthopaedics |  |  |
| Dermatology |  |  | Outpatients |  |  |
| Diabetes + BM Testing |  |  | Paediatrics |  |  |
| Diagnostic Imaging X-Ray |  |  | Palliative Care |  |  |
| Dialysis |  |  | PCIU |  |  |
| Diet and Nutrition |  |  | Peg Feeding |  |  |
| Domiciliary Care |  |  | Physiologists |  |  |
| Drugs and Alcohol |  |  | Plastic Surgery |  |  |
| ECG – Electrocardiogram |  |  | Prisons |  |  |
| Elderly Care |  |  | Radiology |  |  |
| Emergency Admissions Unit |  |  | Recovery |  |  |
| Endoscopy |  |  | Renal |  |  |
| ENT – Ear, Nose, Throat Ward |  |  | Respiratory |  |  |
| General Wards |  |  | Rheumatology |  |  |
| Gynaecology |  |  | SCABU – Special Care Baby Unit |  |  |
| Haematology |  |  | Stroke Unit |  |  |
| HDU – High Dependency Unit |  |  | Surgical |  |  |
| Health Visitor |  |  | Theatres |  |  |
| ITU – Intensive Care Unit |  |  | Tracheostomy Care |  |  |
| IV Drug Administration |  |  | Trauma |  |  |
| Learning Disabilities |  |  | Triage |  |  |
| Medical Health – Assess/Invest |  |  | Urinalysis |  |  |
| Medicine |  |  | Urology |  |  |
| Mental Health |  |  | Venepuncture |  |  |
| Midwifery |  |  | Walk in Centres |  |  |
| MIU – Minor Injuries Unit |  |  | Women’s Health Unit |  |  |

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| **YOUR DECLARATION** |

**1.HEALTH**

*I declare that the answers given within the Declaration of Health form are true and complete to the best of my knowledge and belief. I understand that making false statements or failure to declare health problems could lead to my removal from WNA /HMR.*

**2.TERMS & CONDITION**

*I confirm that the information given in this application is, to the best of my knowledge, true. I am permitted to work in the UK. I understand that my registration is subject to the receipt of at least two satisfactory references and enhanced disclosure form the Disclosures and Barring Service. I undertake to inform WNA/HMR should I be convicted of an offence in the future. I undertake to inform WNA/HMR immediately if I am engaged through their induction, including the offer of permanent employment following temporary assignment. I agree to respect the confidentiality of patient and any other information I may have access to, at all times. I have read, retained a copy of, and fully understand the attached “Rules for members working in hospitals”. I am clear that WNA/HMR work on a temporary assignment and cannot guarantee any number of hours; they have no responsibility to pay for hours not worked, regardless of the situation. I have read, understood and agree to the terms &conditions of work for temporary agency worker, of which I have been given a copy.*

**3. INDUCTION /INTERVIEW**

*I have received a copy of the members handbook and can confirm that I am aware that more detailed information on the Policy and Procedure can be obtain directly from WNA /HMR.*

**4. WORKING TIME REGULATION**

*For the purpose of the Working Time Regulations, 1998 (as amended),I consent to work in excess of the average of 48 hours per week. I understand that I may withdraw this consent by giving WNA/HMR not less than one week notice. I understand that my registration with WNA/HMR can be terminated at any time, following unsatisfactory work reports.*

**5. CONSENT FORM**

*I give my consent to WNA/HMR, to keep an e-file of all my mandatory documents, certificates and correspondence. These may include medical records and questionnaires.*

**6. DATA PROTECTION**

*I agree that WNA /HMR Limited retains their right to hold this application and any other data required to process it and to pass on to any authorised third party the details held within, also to retain these details for as long as reasonably necessary in accordance with the Data Protection Act.*

**7. AGENCY WORKER CONFIDENTIALITY AGREEMENT**

*I agree that any information given or obtained by me in the course of any placement will be kept in the strictest confidence and in a safe and secure place. I acknowledge no information is to be removed from client premises without the permission of the Client. Any information used will be for the purpose of work and will not be disclosed to third parties or copied except as required in the course of my duties. I agree that any breach of this undertaking by me or any third party to whom i release the information to, may result in legal action proceedings being commenced against me including a claim for the recovery of any losses or damages incurred by the Client as a result of that breach.*

*8.* [***WNA HEALTHCARE BULLYING AND HARASSMENT***](http://wna.healthcare/)

*I agree that I have read and understood the* [*Bullying and Harassment*](http://wna.healthcare/harrassment-bullying) *policy which I have downloaded using the link in this declaration.*

***9. 48 HOUR OPT OUT***

*I agree that I have read and understood the 48 hour Opt Out* [Agreement](http://wna.healthcare/48-hours-opt-out) *which I have downloaded using the link in this declaration*

***10. YOUR WORK HEALTH ASSESSMENT GUIDANCE***

*The Work Health Assessment requirement as laid down by the Department of Health is that members must complete a health questionnaire to ensure that they are fit to carry out the duties required. For new starter members WNA/HMR you are required to conduct an Occupational health pre-employment screening prior to your first placement. This must be updated on an annual basis.*

***11. WNA & HMR HANDBOOK DECLARATION***

*I agree I have received a copy of the latest* [*WNA & HMR staff Handbook*](http://wna.healthcare/pub/58caa35d29d26) *via the link which outlines the goals, policies, procedures and expectations of WNA & HMR, its clients and my responsibilities as an employee.*

***12. Equal Opportunities – Equality Act 2010***

*WNA/HMR have a clear objective and policy to embrace all of the principles of equality and opportunity. All staff are expected to operate within the framework of this policy. As part of the monitoring process, we encourage all joining members to complete the form. This can be downloaded by selecting this link -* [*Equal Opportunities Form*](http://wna.healthcare/register)

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| **SIGNED:** |  | **DATE:** | 31 March 2017 |
| **YOUR WORK ASSESSMENT HEALTH GUIDANCE** | | | | | |

The Work Health Assessment requirement as laid down by Department of Health is that members must complete a health questionnaire to ensure that they are fit to carry out the duties required. For new starter members WNA/HMR is required to conduct Occupational health pre–employment screening prior to your first placement. This must also be updated on an annual basis.

Please read the following and state if applicable:

1. I am not aware of any health conditions or disability which may impair my ability to undertake effectively the duties of the position which I have been offered.

Yes  No 

 2. I do have a health condition or disability which might affect my work and which might require special adjustments to my work or at my place of work

Yes  No 

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| **If you have answered “YES” please provide details below.** |
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| **NAME** |  | **SIGNATURE** |  |

**CONFIDENTIALITY**

Information contained within this document is governed by the Data Protection Act 1998. Disclosure of information is only with your informed written consent. Recommendations to your employer will be directed to essential information regarding your health, hazards & risks of your employment, and with due reference to other relevant statutory requirements and professional practice.

**OCCUPATIONAL HEALTH SERVICE**

We run a full service at our office. Our prices are on average 25% cheaper than the NHS[1]. Appointments are not usually required as our nurse is on-site. We cover vaccinations and blood tests for MMR, Varicella and Hepatitis B. Although we can verify a BCG scar, we do not carry out the tests or vaccination – please contact your local Occupational Health department at Royal Bournemouth Hospital or Christchurch hospital for this. Please be aware that for all hospital work you will need a current and valid Fitness to Work certificate.   
 [1] Source: Royal Bournemouth hospital Occupational health 2014.

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| **AVAILABILITY QUESTIONNAIRE** |

1. **Where did you hear about us?**

Internet Search  Job Centre 

Social Media  Leaflet 

Recommendation  Other (please specify) 

1. **Would this be your main job or secondary income?**

Main Job  Secondary Income 

1. **Approximately how many shifts would you like to work per week?**

1-2  2-4  4+ 

1. **What is your preferred shift pattern?**

Early  Late  Night 

Long Day  No Preference 

1. **Please detail dates of any time off or planned holiday**

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1. **Please choose your preferences for establishments**

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| --- | --- | --- | --- | --- |
|  | **Hospitals** | **Community** | **Nursing Homes** | **Prisons** |
| **South** |  |  |  |  |
| **South East** |  |  |  |  |
| **South West** |  |  |  |  |
| **Midlands** |  |  |  |  |
| **North** |  |  |  |  |

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| **Other/ specific locations** |  |

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| **NEW APPLICANT INTERVIEW** |

**Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_**

**Location:** WNA Office Your Home Other Location Please list

**How was your ID verified?**

Skype  Face-to-Face Meeting  Face Time  Trust 

Other  If yes, please state

|  |  |
| --- | --- |
| What experience do you have in the Healthcare Sector? |  |
| What are you mainly looking to get out of joining our Agency? |  |
| What qualities do you feel you have to make this role a success? |  |
| What do you enjoy most about the Healthcare industry? |  |
| What do you least enjoy about the Healthcare industry? |  |
| Do you consider yourself to be social? If so, give an example of where your social skills helped the patient. |  |
| Have you been involved in an emergency situation on your own? What did you do? |  |
| Can you explain the term “Whistleblowing”? and problems associated with it? |  |
| Can you explain the term “Confidentiality”, and how do you maintain it? |  |
| Can you explain your understanding of the term “Vulnerable” and what would you do if someone was being exploited? |  |
| **Interviewer Name** |  |
| **Interviewer Position** |  |
| **Interviewer Signature** |  |