

15 New Fields Business Park, 2 Stinsford Road, Poole, Dorset, BH17 0NF

Tel: 01202 665550, Fax: 01202 665568

WNA Healthcare HMR Medical & Nursing

Tel Ext: Option 1, 2 Tel Ext: Option 2, 1

apply@wna.healthcare 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**  |

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| **NAME** |  |
| **POSITION (RGN / RMN / HCA)** |  |
| **RECOMMENDED BY** |  |
| **REVIEWED BY** |

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| --- |
| Maria Alibhai (86E0211E) |

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| **SIGNED BY** | **M.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** |  |

**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 belowHave 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  NoIf 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. GDPR CONSENT AND DATA PROTECTION**

*I hereby give my consent to WNA/HMR to process the following information –* ***Personal data*** *(name, date of birth, contact details, telephone numbers, email address, postal address, experience, training, qualifications, CV, national insurance number, gender, nationality, next of kin),* ***Sensitive personal data*** *(disability/health condition relevant to the role, occupational health, criminal conviction).*

I consent to WNA/HMR to process the above personal data for the following purposes:

* *to provide me with work-finding services, to process or transfer my personal data to their client/s in order to provide me with work-finding services, to process my data on a computerised database in order to provide me with work-finding services, to process my data using automated decision making processes, to process my personal data with third parties including for the purposes of internal/external audits, investigations and complaints carried out on WNA/HMR to ensure that the company is complying with all laws and regulations.*

**6. 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.*

*7.* [***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) *(*<https://wna.healthcare/harrassment-bullying>) *policy which I have downloaded using the link in this declaration.*

***8. 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) (<https://wna.healthcare/48-hours-opt-out>) *which I have downloaded using the link in this declaration*

***9. 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.*

***10. WNA & HMR HANDBOOK DECLARATION (Issue 1, Rev 11)***

*I agree I have received a copy of the latest* [*WNA & HMR staff Handbook*](http://wna.healthcare/pub/58caa35d29d26)(<https://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.*

***11. 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)(https://wna.healthcare/pub/58de43c563940)

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| **SIGNED:**  |  | **DATE:**  |  |
| **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**

Although we can verify a BCG scar via our onsite Nurse, we do not carry out any blood tests or vaccinations. Please contact your local Occupational Health department or GP if you require this service.

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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** |  |

***Healthcare Assistant Job Description***

**All Agency members are required to:**

* Report to the Agency on a weekly basis with availability for work. All staff are offered duties when available to their stipulated days free, although the Agency will ring all Members on the list when Emergency Cover is requested.
* Turn up for duty when you have accepted a shift as it is expected that you will attend when you have accepted a shift, unless an Emergency Situation occurs concerning yourself or a family member.

**All cancellations will be recorded regardless of grade.**

* Report for duty at allocated place of work in adequate time, wearing appropriate uniform and ID Badge. It is also advisable to carry your NMC Pin Card.
* Represent the Agency with high standards of nursing care, delivered in a polite, conscientious manner and to ensure that patient privacy, independence and dignity are maintained at all times.
* Assist with General Nursing Skills at appropriate skill level at allocated place of work.
* Be aware of all the current aspects of the Health and safety at Work Act, to be aware of Fire Drills and Emergency Procedures at place of work affecting you, patients and colleagues.
* Report any accidents/incidents direct to the person in charge of your allocated place of work, and if necessary to alsoreport it to the Manager in charge of the Agency. Ensure all accidents are written in the correct book at the allocated place of work.
* Administer all medications in line with the NMC Guidelines for the administration of medicines.
* Ensure that all original timesheets are correctly completed and signed on the day of duty and are sent into the Office weekly, they need to reach the Office by 1pm on Tuesdays (by first post Wednesday following a Bank Holiday Monday). Failure to do this may result in a delay in payment.
* Ensure that you have given the correct Bank/Building Society details on your Application Form and it is your responsibility to inform the Office if these details change. This is because Wages are paid on weekly BACS system.
* Purchase your own Uniform, although the Agency can order this for you. Costs vary according to size and design. The Uniform required is a Navy blue tunic with white piping (Women and Men), black/navy blue trousers and sensible black shoes.
* Ensure you attend an Induction Course initially and please also try to attend the Training Courses that are offered to you.
* Update Mandatory training as per Skills for Health, Core Skills Training Framework and others as necessary for job role. Certificates to be provided to the office

**All members are required to work within the Companies Policies. A copy is available in the Office.**

Please feel free to ring in with any problems you may have as we are here to offer you support.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Trained Nurses Job Description***

**All Trained Nurses to abide to the above for Healthcare Assistants plus the following:**

* Keep up to date with nursing practice according to the NMC Guidelines.
* Administer all medications in line with the NMC Guidelines for the Administration of Medicines.

**All cancellations will be recorded regardless of grade.**

**All members are required to work within the Companies Policies. A copy is available in the Office.**

Please feel free to ring in with any problems you may have as we are here to offer you support.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  **Key Information Document for PAYE**

This document sets out key information about your relationship with us, including details about pay, holiday entitlement and other benefits.

Further information can be found at accounts@wna.healthcare

The Employment Agency Standards (EAS) Inspectorate is the government authority responsible for the enforcement of certain agency worker rights. You can raise a concern with them directly on 020 7215 5000 or through the Acas helpline on 0300 123 1100, Monday to Friday, 8am to 6pm.

**GENERAL INFORMATION**

|  |  |
| --- | --- |
| **Your Name:** |  |
| **Name of employment business:** | Wimborne Nursing Agency Limited t/a WNA Healthcare |
| **Your employer (if different from the employment business):** | N/A |
| **Type of contract you will be engaged under:** | Contract for Services |
| **Who will be responsible for paying you (if different from your employer):** | N/A |
| **How often you will be paid:** | Weekly |
| **Expected or minimum rate of pay:** | No less than National Minimum Wage |
| **Deductions from your pay required by law:** | PAYE Tax, Employee NI Contributions, Employee Pension Contributions (i.e. auto enrolment) |
| **Any other deductions or costs from your pay (to include amounts or how they are calculated):** | N/A |
| **Any fees for goods or services:** | DBS, PVG, Training, Uniform |
| **Holiday entitlement and pay:** | Statutory Annual Leave Entitlement 5.6 weeks/28 days for full time, part-time pro-rated accordingly |
| **Additional benefits:** | N/A |

**EXAMPLE PAY**

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| **Example rate of pay:** | £25 x 40hrs = £1000.00(National Minimum Wage) |
| **Deductions from your wage required by law:** | Tax Code: 1257L**I**ncome Tax = £158.2 (20% - £145/40% - £13.2)National Insurance = £83.72 |
| **Any other deductions/costs from wage:** | - |
| **Any fees for goods or services:** | - |
| **Example net take home pay:** | £758.08 |

**(Source:** [**http://payecalculator.hmrc.gov.uk/PAYE1.aspx**](http://payecalculator.hmrc.gov.uk/PAYE1.aspx) **)**

**Key Information Document for Umbrella**

This document sets out key information about your relationship with us and the intermediary or umbrella company used in your engagement, including details about pay, holiday entitlement and other benefits.

Further information can be found at accounts@wna.healthcare

The Employment Agency Standards (EAS) Inspectorate is the government authority responsible for the enforcement of certain agency worker rights. You can raise a concern with them directly on 020 7215 5000 or through the Acas helpline on 0300 123 1100, Monday to Friday, 8am to 6pm.

**GENERAL INFORMATION**

|  |  |
| --- | --- |
| **Your name:** |  |
| **Name of employment business:** | Wimborne Nursing Agency Limited t/a WNA Healthcare |
| **Name of intermediary or umbrella company:** |  |
| **Your employer:** | Umbrella |
| **Type of contract you will be engaged under:** | Contract of Services |
| **Who will be responsible for paying you:** | Umbrella |
| **How often the umbrella company and you will be paid:** | Weekly |

**INTERMEDIARY OR UMBRELLA COMPANY PAY INFORMATION**

You are being paid through an intermediary or umbrella company: a third-party organisation that will calculate your tax and other deductions and then pay you for the work undertaken for the hirer. We will still be finding you assignments.

The money earned on your assignments will be transferred to the umbrella company as part of their income. They will then pay you your wage. All the deductions made which affect your wage are listed below. If you have any queries about these please contact us.

Your payslip may show you as an employee of the umbrella company listed below.

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| **Name of intermediary or umbrella company:** |  |
| **Any business connection between the intermediary or umbrella company, the employment business and the person responsible for paying you:** |  |
| **Expected or minimum gross rate of pay transferred to the intermediary or umbrella company from us:** | No less than National Minimum Wage |
| **Deductions from intermediary or umbrella income required by law:** | PAYE Tax, Employee NI Contributions, Employee Pension Contributions (i.e. auto enrolment) |
| **Any other deductions from umbrella income (to include amounts or how they are calculated)**  | - |

|  |  |
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| **Expected or minimum rate of pay to you:** | No less than National Minimum Wage |
| **Deductions from your wage required by law:** | PAYE Tax, Employee NI Contributions, Employee Pension Contributions (i.e. auto enrolment) |
| **Any other deductions or costs taken from your wage (to include amounts or how they are calculated:** | Umbrella Fee |
| **Any fees for goods or services:** | DBS, PVG, Training, Uniform |
| **Holiday entitlement and pay:** | Statutory Annual Leave Entitlement 5.6 weeks/28 days for full time, part-time pro-rated accordingly |
| **Additional benefits:** | **-** |

**EXAMPLE PAY**

|  |  |  |
| --- | --- | --- |
|  | **Intermediary or umbrella fees** | **Worker fees** |
| **Example gross rate of pay to intermediary or umbrella company from us:** | £1000 per week |  |
| **Deductions from intermediary or umbrella income required by law:** | Employee Tax - £126.89Employee NI - £83.06Apprenticeship Levy 0.5% - £4.38Employer NI - £97.45 |  |
| **Any other deductions or costs taken from intermediary or umbrella income:** | Umbrella Fee £22.00 |  |
| **Example rate of pay to you:** |  | £25 |
| **Deductions from your pay required by law:**  |  |  |
| **Any other deductions or costs taken from your pay:** |  |  |
| **Any fees for goods or services:** |  | **-** |
| **Example net take home pay:** |  | £666.22 |

**(Source:** <https://www.contractorumbrella.com/resource/how-does-an-umbrella-company-calculate-my-take-home-pay/>**)**

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| **NEW APPLICANT INTERVIENEW APPLICANT INTERVIEW** |

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

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

**Location:** WNA Office Office Home Other, please list

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| 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? |  |
| How would you deal with a **difficult patient**? |  |
| Can you explain the term “**Confidentiality**”, and how do you maintain it? |  |
| Can you explain the term **“UTI**” and what is the primary cause of this? |  |
| Can you explain the term “**Vulnerable**” and what would you do if someone was being exploited? |  |
| **Interviewer Name** | Maria Alibhai  |
| **Interviewer Position** | Director (86E0211E)  |
| **Interviewer Signature** | **M.Alibhai**  |