

15 New Fields Business Park

2 Stinsford Road, Poole, Dorset

BH17 0NF

Tel: 01202 665550

Fax: 01202 665568

apply@wna.healthcare

[www.wna.healthcare](http://www.wna.healthcare)

 

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2 Stinsford Road, Poole, Dorset

BH17 0NF

Tel: 01202 665550

Fax: 01202 665568

nursing@hmr.co.uk

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



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|  **YOUR APPLICATION PACK**  |

|  |  |
| --- | --- |
| **NAME** | Click or tap here to enter text. |
| **POSITION (RGN / RMN / HCA)** | Choose an item. |
| **RECOMMENDED BY** | Click or tap here to enter text. |
| **REVIEWED BY** |

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| Maria Alibhai (86E0211E) and Click or tap here to enter text. |

 |
| **SIGNED BY** |  **Maria Alibhai**  |

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

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| **WNA** | [ ]  | **HMR** | [ ]  |

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| **DATE** | 3 November 2016 |

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

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| **SIGNATURE** | Click or tap here to enter text. |

**APPLICATION PACK MUST BE RETURNED WITHIN 7 DAYS – PLEASE READ BEFORE COMPLETING**

At times WNA Healthcare is shortened to **WNA** & HMR Medical & Nursing Service is shortened to **HMR**.

**APPLICANTDETAILS**

*You will need to provide evidence that confirms your Personal Identification and address.*

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| **YOUR PERSONAL DETAILS** |
| **TITLE** | Choose an item. | **SURNAME** | Click or tap here to enter text. |
| **FORENAME** | Click or tap here to enter text. |
| **MIDDLE NAME** | Click or tap here to enter text. |
| **MAIDEN NAME** | Click or tap here to enter text. |
| **MARITAL STATUS** | Choose an item. |
| **D.O.B.** | Click or tap to enter a date. |
| **ADDRESS** | Click or tap here to enter text. |
| **TOWN** | Click or tap here to enter text. |
| **COUNTY** | Click or tap here to enter text. |
| **POSTCODE** | Click or tap here to enter text. |
| **LANDLINE PHONE**  | Click or tap here to enter text. |
| **MOBILE PHONE**  | Click or tap here to enter text. |
| **EMAIL** | Click or tap here to enter text. |
| **NEXT OF KIN DETAILS** |
| **FULL NAME**  | Click or tap here to enter text. |
| **RELATIONSHIP** | Click or tap here to enter text. |
| **ADDRESS** | Click or tap here to enter text. |
| **TOWN** | Click or tap here to enter text. |
| **COUNTY** | Click or tap here to enter text. |
| **POSTCODE** | Click or tap here to enter text. |
| **LANDLINE PHONE**  | Click or tap here to enter text. |
| **MOBILE PHONE** | Click or tap here to enter text. |
| **EMAIL** | Click or tap here to enter text. |

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| **TRANSPORT DETAILS** |
| **CAR** |[ ]  **PUBLIC TRANSPORT** |[ ]

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| **NMC DETAILS** |
| **NMC NUMBER** | Click or tap here to enter text. | **NMC EXPIRY DATE** | Click or tap to enter a date. |
| **NMC PART(s) OF REGISTER** | Click or tap here to enter text. | **NMC PART(s) EXPIRY DATE** | Click or tap to enter a date. |
| **PROFESSIONAL INDEMNITY INSURANCE UNION** | Click or tap here to enter text. |

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| **OTHER (Please specify)** | Click or tap here to enter text. |

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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** | Click or tap here to enter text. |
| **NATIVE LANGUAGE** | Click or tap here to enter text. |
| **NATIONAL INSURANCE NUMBER** | Click or tap here to enter text. |

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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)** |

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| **OTHER:** | Click or tap here to enter text. |
| **WORK PERMIT EXPIRY DATE:** | Click or tap to enter a 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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| I wish to be paid through:  | **P.A.Y.E (enclose P45)** [ ]  | **Ltd Company (Enclose company proof)** [ ]  |

**You will need to provide evidence of your bank account**

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|  **BANK DETAILS** |
| **ACCOUNT HOLDER NAME** | Click or tap here to enter text. |
| **COMPANY NAME (if applicable)** | Click or tap here to enter text. |
| **NAME OF BANK** | Click or tap here to enter text. |
| **ADDRESS** | Click or tap here to enter text. |
| **ADDRESS 2** | Click or tap here to enter text. |
| **TOWN** | Click or tap here to enter text. |
| **COUNTY** | Click or tap here to enter text. |
| **POSTCODE** | Click or tap here to enter text. |
| **SORT CODE** | Click or tap here to enter text. |
| **ACCOUNT NUMBER** | Click or tap here to enter text. |

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| **YOUR EMPLOYMENT HISTORY** |

*\*\* Please supply details of your full history starting from secondary school to date.*

*\*\* Please explain the gaps in your history.*

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

*\*\* Please continue on a different sheet if required.*

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| **DATE****FROM****MM/YY** | **DATE TO****MM/YY** | **EMPLOYER’S NAME AND ADDRESS** | **POSITION** | **REASON****FOR LEAVING** |
| Click or tap to enter a date. | Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| **YOUR PROFESSIONAL CONDUCT** |
| Have there been any proceedings of medical negligence or professional misconduct against you and have you ever been suspended or dismissed? Yes[ ]  No [ ]  |

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| **If “YES” please supply details:** | Click or tap here to enter text. |

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| **REHABILITATION OF OFFENDERS ACT** |
| 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 Rehabilitation of Offenders act (1974) (Exceptions) Order 1975 applies. 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 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[ ]  |

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| **If “YES” please supply details:** | Click or tap here to enter text. |
| **NAME :**  | Click or tap here to enter text. | **SIGNATURE:**  | Click or tap here to enter text. |

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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** | Click or tap here to enter text. | **GRADE** | Click or tap here to enter text. | **DOB** | Click or tap to enter a date. |

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|  **1st Reference – Senior Clinical** |
| **NAME** | Click or tap here to enter text. |
| **POSITION** | Click or tap here to enter text. |
| **ADDRESS** | Click or tap here to enter text. |
| **TOWN** | Click or tap here to enter text. |
| **COUNTY** | Click or tap here to enter text. |
| **POSTCODE** | Click or tap here to enter text. |
| **PHONE NUMBER** | Click or tap here to enter text. |
| **FAX NUMBER** | Click or tap here to enter text. |
| **EMAIL ADDRESS** | Click or tap here to enter text. |

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|  **2nd Reference – Clinical** |
| **NAME** | Click or tap here to enter text. |
| **POSITION** | Click or tap here to enter text. |
| **ADDRESS** | Click or tap here to enter text. |
| **TOWN** | Click or tap here to enter text. |
| **COUNTY** | Click or tap here to enter text. |
| **POSTCODE** | Click or tap here to enter text. |
| **PHONE NUMBER** | Click or tap here to enter text. |
| **FAX NUMBER** | Click or tap here to enter text. |
| **EMAIL ADDRESS** | Click or tap here to enter text. |

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|  **3rd Reference** |
| **NAME** | Click or tap here to enter text. |
| **POSITION** | Click or tap here to enter text. |
| **ADDRESS** | Click or tap here to enter text. |
| **TOWN** | Click or tap here to enter text. |
| **COUNTY** | Click or tap here to enter text. |
| **POSTCODE** | Click or tap here to enter text. |
| **PHONE NUMBER** | Click or tap here to enter text. |
| **FAX NUMBER** | Click or tap here to enter text. |
| **EMAIL ADDRESS** | Click or tap here to enter text. |

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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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| --- | --- | --- | --- | --- | --- |
| **General Experience** | **0-12 months** | **1 year +** | **General Experience** | **0-12 months** | **1 year +** |
| **Medicine** |[ ] [ ]  **Learning Disabilities** |[ ] [ ]
| **Surgical** |[ ] [ ]  **Domiciliary Care** |[ ] [ ]
| **Mental Health** |[ ] [ ]  **Nursing Homes** |[ ] [ ]
| **Prisons** |[ ] [ ]  **Observation Records** |[ ] [ ]
| **HCA Only** | **0-12 months** | **1 year +** | **HCA Only** | **0-12 months** | **1 year +** |
| **Urinalysis** |[ ] [ ]  **Toileting** |[ ] [ ]
| **BM Testing (Diabetes)** |[ ] [ ]  **Mobility** |[ ] [ ]
| **Personal Hygiene** |[ ] [ ]  **Nutrition** |[ ] [ ]
| **Others** |[ ] [ ]  **Record Keeping** |[ ] [ ]

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| **Hospital Experience** | **0-12 months** | **1 year +** | **Hospital Experience** | **0-12 months** | **1 year +** |
| **A & E** |[ ] [ ]  **Paediatric A&E** |[ ] [ ]
| **Cardiac** |[ ] [ ]  **Paediatrics** |[ ] [ ]
| **Chemotherapy** |[ ] [ ]  **Palliative Care** |[ ] [ ]
| **Clinics** |[ ] [ ]  **PCIU** |[ ] [ ]
| **Community** |[ ] [ ]  **Plastic Surgery** |[ ] [ ]
| **Coronary Care Unit** |[ ] [ ]  **Radiology** |[ ] [ ]
| **Diagnostic Imaging X - ray** |[ ] [ ]  **Recovery** |[ ] [ ]
| **Dialysis** |[ ] [ ]  **Renal** |[ ] [ ]
| **Elderly Care** |[ ] [ ]  **SCBU** |[ ] [ ]
| **Endoscopy** |[ ] [ ]  **Surgical** |[ ] [ ]
| **General wards** |[ ] [ ]  **Theatres** |[ ] [ ]
| **Gynaecology** |[ ] [ ]  **Triage** |[ ] [ ]
| **Health Visitor** |[ ] [ ]  **Urology** |[ ] [ ]
| **High Dependency Unit** |[ ] [ ]  **NICU** |[ ] [ ]
| **Walk in Centres** |[ ] [ ]  **Nurse Practitioner**  |[ ] [ ]
| **ITU - Intensive Care Unit** |[ ] [ ]  **Occupational Health** |[ ] [ ]
| **Learning Disabilities** |[ ] [ ]  **ODP** |[ ] [ ]
| **Medical Health** |[ ] [ ]  **Oncology** |[ ] [ ]
| **Mental Health** |[ ] [ ]  **Orthopaedics** |[ ] [ ]
| **Midwifery** |[ ] [ ]  **Neonatal** |[ ] [ ]

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| **YOUR DECLARATION** |

**1.HEALTH**

*I declare that the answers given within this Declaration of Health on this 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 removal from WNA /HMR.*

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| **SIGNED:**  | Click or tap here to enter text. | **DATE:**  | 3 November 2016 |

**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 the 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.*

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| **SIGNED:**  | Click or tap here to enter text. | **DATE:**  | 3 November 2016 |

**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.*

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| **SIGNED:**  | Click or tap here to enter text. | **DATE:**  | 3 November 2016 |

**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.*

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| **SIGNED:**  | Click or tap here to enter text. | **DATE:**  | 3 November 2016 |

**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.*

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| **SIGNED:**  | Click or tap here to enter text. | **DATE:**  | 3 November 2016 |

**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.*

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| **SIGNED:**  | Click or tap here to enter text. | **DATE:**  | 3 November 2016 |

**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.*

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| **SIGNED:**  | Click or tap here to enter text. | **DATE:**  | 3 November 2016 |

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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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| Click or tap here to enter text. |

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

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| --- | --- | --- | --- | --- |
|  | **Hospitals** | **Community** | **Nursing Homes** | **Prisons** |
| **South** |[ ] [ ] [ ] [ ]
| **South East** |[ ] [ ] [ ] [ ]
| **South West** |[ ] [ ] [ ] [ ]
| **Midlands** |[ ] [ ] [ ] [ ]
| **North** |[ ] [ ] [ ] [ ]
| **Other/ specific locations** | Click or tap here to enter text. |

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| **YOUR WORK HEALTH ASSESSMENT 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.** |
| Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** | Click or tap here to enter text. | **SIGNATURE** | Click or tap here to enter text. |

**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.