Registration Information for New Applicants

DOCUMENT CHECKLIST (FOR OFFICE USE ONLY)

APPLICANTS PLEASE PROCEED TO PAGE 2

Document Type	Provided? (Yes / No)	If no to any, please give reason why:	Document Scanned?
Copy of Passport	Select		
Copy of the Front Cover of Passport	Select		
Copy of Visa / Permit Status (spouse copy where applicable to individuals status)	Select		
Copy Birth Certificate	Select		
Copy of Marriage Certificate (If applicable)	Select		
Copy of National Insurance Card	Select		
Copy of Driver's license (If applicable)	Select		
Copy of Relevant training certificates	Select		
Copy of evidence of vaccination status	Select		
Copy of two proofs of address	Select		
Copy of recent CV	Select		
Professional Indemnity Insurance (If wishing to work self employed)	Select		
Registered Nurses			
Pin Number and NMC statement of entry	Select		
RCN Membership Card (front & back)	Select		
RCN Membership Card (front & back)	Select		
Evidence of additional qualification	Select		
Portfolio	Select		

If you have any pertinent questions about the application process, please contact us:

Call: 0208 075 1651 | Email: info@mjqualitycare.co.uk | www.mjqualitycare.co.uk

APPLICANT SECTION

A. YOUR PERSONAL DETAILS (PLEASE ADD YOUR INFORMATION BELOW)

Title (MRS, MISS, MS, MR or other title)

Surname or family name

First name(s)

Name preferred to be known by

All other surnames or family names (including maiden name & name changes)

Address	Postcode
Daytime phone number	
Mobile number	
E-mail address	
Do you hold a current full UK driving license? (YES / NO)	YES ☐ NO ☐

B. YOUR NMC DETAILS (FOR REGISTERED NURSES ONLY)

It is your responsibility to keep us updated with any changes to your personal details.

NMC pin number	NMC expiry date / /
NMC Part(s) of register	

If you have any issues or investigations outstanding on your NMC PIN please let us know in writing via email to **info@mjqualitycare.co.uk**

Please tick here if you are currently on sick leave and provide details below:

YES ☐ NO ☐

C. YOUR PASSPORT DETAILS

Passport number:	Date of birth: / /
Your nationality:	
Please tell us about your eligibility to work in the UK:	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 the UK.
If other please specify:	

D. FORMER NAMES

- If you have changed your legal name at any time, you must provide details below
- This includes changes of first name or surname due for any reason
- There must be no gaps in the record of any former names

DATE FROM (DD/MM/YY)	**DATE TO** (DD/MM/YY)	**FULL LEGAL NAME BETWEEN THESE DATES**	**REASON FOR CHANGE (i.e. MARRIAGE, DEED POLL)**

E. EDUCATION AND QUALIFICATIONS

Professional qualification

Issuing College / University

Year of graduation

Any additional qualifications

F. YOUR EMPLOYMENT HISTORY

- Please supply details of your full history starting from secondary school to date or the past 10 years (whichever is shorter).
- Please explain any gaps in your history.
- Comprehensive CV is acceptable provided it lists your full history from secondary school, and details of the months & years.
- Please continue on a different sheet if required.

DATE FROM (MM/YY)	**DATE TO** (MM/YY)	**EMPLOYER'S NAME AND ADDRESS**	**PRINCIPLE DUTIES**	**GRADE**	**REASONS FOR LEAVING**

G. YOUR PROFESSIONAL EXPERTISE

Please tick up to 5 boxes, with the clinical areas you have expertise in:

☐ A&E	☐ Cardiac	☐ Clinics
☐ Community	☐ Diagnostic Imaging x-ray	☐ Elderly Care
☐ Endoscopy	☐ General Wards	☐ Gynaecology
☐ HDU	☐ Health Visitor	☐ Homecare
☐ DITU	☐ Learning Disabilities	☐ Medical
☐ Mental Health	☐ Midwifery	☐ Neonatal
☐ NICU	☐ 7 Nurse Practioner	☐ Nursing Homes
☐ Occupational Health	☐ ODP	☐ Oncology
☐ Chemotherepy	☐ Orthopaedics	☐ Pediatric A&E
☐ Paediatrics	☐ Palliative	☐ PICU
☐ Practice Nurse	☐ Prison	☐ Radiology
☐ Recovery	☐ Renal	☐ Dialysis
☐ SCBU	☐ Surgical	☐ Theatre
☐ Triage	☐ Urology	☐ Walk in centre
☐ Dieticians	☐ Psychologists	☐ Radiographers
☐ Occupational Therapists	☐ Physiotherapists	☐ Podiatrists
☐ Orthoptists	☐ Speech and Language Therapists	☐ Pathologists
☐ Biomedical Scientists	☐ Cytologists	☐ Dental Service Staff
☐ Genetic Counsellors	☐ Health Scientists	☐ Medical Technologists
☐ Optometrists	☐ Pharmacy Staff	

H. 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 ☐

If "YES" please supply details:

I. 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 the Rehabilitation of Offenders Act (1974) (Exceptions) Order 197 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 completely confidential and will be considered only in relation for positions to which the order applies. We may have to disclose information regarding convictions to our clients prior to booking.

Have you at anytime been convicted of an offence? (YES / NO) YES ☐ NO ☐

If your answer is "YES" please state below the nature and circumstances of the offence, the consequences of your conviction and a reflection of your conduct:

J. ADDRESS HISTORY

Any individual paid by Pennine Social Care must complete an address history form to give us a list of all addresses where you have lived for the last 5 years. This is required for DBS (Disclosure and Barring Service) purposes. You must disclose all addresses including anywhere you have lived in the United Kingdom or any other countries, along with approximate dates (to the nearest month) when you lived at each address. If you have more previous addresses than will fit on this form, please continue on the back of the page.

The form will be returned to you if essential information (marked *) is omitted.

PLEASE COMPLETE ALL SECTIONS IN BLOCK CAPITALS AND SIGN THE DECLARATION THEN PASS THE COMPLETED FORM TO THE MANAGER.

FULL ADDRESS INCLUDING POSTCODE	APPROX. DATE YOU MOVED IN	APPROX DATE YOU MOVED OUT

K. YOUR BANK DETAILS, NATIONAL INSURANCE NUMBER & PAYE STATUS

We pay your wages directly into a bank account.

Account holder name	
Branch address	
	Postcode
Sort code	Account number
National Insurance Number	

I wish to be paid through a Ltd Company and enclose details. ☐

Read all the following statements carefully and tick the one box that applies to you.

A. This is my first job since 6 April and I have not been receiving any taxable benefits or a state or occupational pension. ☐

B. This is now my only job, but since 6 April I have had another job, or have received taxable benefits or a state or occupational pension. ☐

C. I have another job or receive a state or occupational pension. ☐

L. YOUR NEXT OF KIN DETAILS

1	Name:	
	Relationship to you:	
	Address:	
		Postcode:
	Daytime phone number:	Mobile phone number:
2	Name:	
	Relationship to you:	
	Address:	
		Postcode:
	Daytime phone number:	Mobile phone number:

It is your responsibility to keep us updated with any changes to your next of kin details.

M. YOUR REFERENCE DETAILS

- Please supply the names and work addresses of at least two professional referees.
- One must be from your present or most recent employer and must be a senior grade to yourself.
- You must have worked for that person for a periodof more than three months in duration.
- The second 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.

NB: If you cannot provide two in date senior references, you cannot register.

May we contact your referees prior to an interview? YES ☐ NO ☐

Reference 1

Name	
Position	
Address	
	Postcode
Daytime phone number	Fax number
Email address	
What was your professional relationship with this person?	
Start Date (mm/yy)	End Date (mm/yy)

Reference 2

Name	
Position	
Address	
	Postcode
Daytime phone number	Fax number
Email address	
What was your professional relationship with this person?	
Start Date (mm/yy)	End Date (mm/yy)

N. HEALTH & WELLBEING DECLARATION

The following questions are to help assess your state of physical and mental health. This is to ensure you can fully carry out your duties of care to the client without any doubt as to your capacity.

YOUR GP'S DETAILS						
Doctor's Name			**Immunisation or Vaccination**	**Yes**	**No**	**Date Completed**
Surgery			Hepatitis B			
Full Address			Tuberculosis (BCG)			
			Tetanus			
			Typhoid			
			MMR (Measles, Mumps, Rubella)			
Post Code			Poliomyelitis (Polio)			
Tel No.			Varicella (Chickenpox)			

HEALTH DECLARATION			
Do you smoke? If yes how many / week			
What is your weekly consumption of alcohol?			
Have you ever had or suffered from any of the Following? **Please provide honest and accurate information**			
	YES	**NO**	**IF YES PLEASE GIVE DETAILS**
Chest pain, heart condition or blood pressure problems?			
Tuberculosis, asthma, bronchitis or chest complaints?			
Epilepsy, fits, fainting or dizziness?			
Ulcers, stomach problems, bowel problems or hernia?			
Rheumatism or arthritis?			
Typhoid, paratyphoid or dysentery?			
Diabetes, typhoid or other gland troubles?			
Bladder or kidney trouble?			
Allergies?			
Skin trouble or dermatitis?			
Varicose veins?			
Any infections or communicable disease?			
Hay fever or sinus trouble?			
Medical condition(s) that may affect your performance?			
Medical condition(s) that may affect your attendance?			
Any illness, accidents, operations in the past two years?			
Any physical disabilities, and / or defect of sight or hearing?			
Any back injury or trouble?			
Do you intend to work night shifts on a regular basis?			
Have you ever had a stay in hospital over 2 weeks?			
Do you have any problems with vision and / or headaches?			

Depression, anxiety, nervous breakdowns or any related conditions?			
Bipolar disorder, schizophrenia or personality disorder?			
Are you currently taking medication on a strict timetable?			
Any hearing loss or ear problems?			

O. HEALTH QUESTIONNAIRE TO ASSESS IF YOU ARE FIT TO WORK NIGHTS

The purpose of this questionnaire is to make sure that you are suited to working at night. All the information you provide will be kept confidential.

About you

First and second name/s:	Surname:
Date of birth:	Sex: Male ☐ Female ☐
Permanent address:	
Postcode:	

Health conditions

Do you suffer from any of the following health conditions?

Diabetes?	YES ☐	NO ☐
Stomach or intestinal disorders?	YES ☐	NO ☐
Any condition which causes difficulties sleeping?	YES ☐	NO ☐
Chronic chest disorders (especially if night-time symptoms are troublesome)?	YES ☐	NO ☐
Any medical condition requiring medication to a strict timetable?	YES ☐	NO ☐
Any other health factors that might affect fitness at work?	YES ☐	NO ☐
Heart or circulatory disorders?	YES ☐	NO ☐

If you have answered 'yes' to any of the above questions, you may be asked to see a doctor or nurse

I, the undersigned, confirm that the above is correct to the best of knowledge

Signed: ..... Date: .....

EMPLOYER'S ASSESSMENT – FOR OFFICE USE ONLY

Your employer should complete the next section with their assessment.

After reviewing the questionnaire, my assessment is that you:

- ☐ Can work nights
- ☐ Can not work nights
- ☐ Should see a doctor or nurse for a medical examination to assess whether you can work nights

Signed: ..... Date: .....

P. YOUR DECLARATIONS

1. HEPATITIS B

I have been advised at the registration office of the importance of having the Hepatitis B vaccine. I acknowledge that I have been/am being vaccinated against Hepatitis B and will continue to maintain my immunity. I accept responsibility for my decision and will ensure that I take all precautions to avoid contracting the illness and avoid accepting work within environments which are hazardous.

Signed Date

2. TERMS & CONDITIONS

Signed Date

3. INDUCTION

I have received a copy of the Induction information letter and can confirm that I have received, read, understood and will comply with the Agency Worker Handbook at all times. I am aware that the latest version of the Handbook is available on our website.

Signed Date

4. WORKING TIME REGULATIONS

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

☐ I consent to work ☐ I do not consent to work

Signed Date

5. BANK DETAILS

I have completed my bank details. I confirm they are complete and correct. I understand that incorrect and incomplete details can delay my payment.

Signed Date

6. DATA PROTECTION

I agree that Pennine Social Care retain the 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 GDPR.

Signed Date

7. RESPONSIBILITY OF COMPLIANCE

Many of your compliance items need to be reviewed annually. It is your responsibility to ensure that your file is in date at all times. If any of your compliance items lapse, it may cause the suspension and/or termination of your placement.

Signed Date

Q. Equal opportunities monitoring self-classification form

This information is being gathered to achieve improvements in Pennine Social Care's equal opportunities policies. We hope you will help us by completing the form. The data will be used only for monitoring purposes and will not be taken into account in assessing information on your application form. The data will be treated in confidence.

Job Title:		Location:	
Title: Mr/Mrs/Miss/Ms/Dr		Surname:	
Forename(s)			
D.O.B		Marital Status:	

What is your ethnic group? Choose one section from A to F, and then tick the box to indicate your cultural background.

A	**White**		**B**	**Black or Black British**	
	British/Scottish/Irish/Welch	☐		Caribbean	☐
	European	☐		African	☐
	Other white background, Please state.....			British	☐

C	Mixed	B	Asian or British Asian
	White & Black Caribbean ☐		Indian ☐
	White & Black African ☐		Pakistani ☐
	White & Asian ☐		Bangladeshi ☐
	White & Black British ☐		British ☐
	Other Mixed background, please state.....		Other Asian backgrounds, please state.....

E	Chinese or other ethnic group	F	Unknown
	Chinese ☐		I do not know my ethnic group ☐
			Withheld ☐
			I do not wish to indicate my ethnic group ☐
	Other ethnic group, please state.....		

Disability N.B. The information in this section will be disclosed to the recruiting manager if you are short-listed for an interview. Under the Disability Discrimination Act 1995, a person has a disability if he or she has a physical or mental health impairment which has a substantial and long-term adverse effect on the ability to carry out normal day-to-day activities.

Do you consider that you have a disability? YES ☐ NO ☐	Nationality / Passport Held:
Does the nature of your disability lead you to require any special equipment/facilities etc. in your work place? YES ☐ NO ☐	If YES please explain:
Signed:	**Date:**

R. INDUCTION INFORMATION

S. UNIFORM REQUEST

Type of uniform and sizes required (please select below)

Polo shirt	☐	Tell us you preferred size	**Small** ☐
Tunic	☐		**Medium** ☐
Long Tunic (dress)	☐		**Large** ☐
			XXL ☐
			XXXL ☐

DOCUMENTATION CHECKLIST (FOR OFFICE USE ONLY)

Please sign and date as each part of documentation is received. Only original copies should be seen and copies taken. All training certificates should be within 12 months and if not available, make referral for training before placements.

Documents	Date Received / Confirmed	Authorised Signature
Original Passport ***Original document****	No: Issue Date:	
Front Cover of Passport		
Work Permit Status or Student Status ***Use immigration manual****		
Proof of Address		
National Insurance Card	No:	
Second Proof of Address/ Second Photo ID		
Two Passport Size Photographs		

Immunisation to include Hep B		
Occupational Health Certificate		
DBS at Enhanced level & ISA Check	Date Sent: Reference No: Date Returned:	
Equal Opportunity Form Signed		
Confirmation of NMC PIN No: ***(Registered nursing staff only)***		
Induction Pack Provided to Staff Member		
P45 / P46 / Most Recent Pay Slip		
Bank Details		
Staff Handbook Signed		
Terms & Conditions Signed		
I.D. Badge & Uniform Provided		
Proof of Professional Indemnity Cover		
Police check from country of origin if you have been in the UK less than 6 months		

REFERENCES (FOR OFFICE USE ONLY)

FIRST REFERENCE		**SECOND REFERENCE**	
Date Sent Off		Date Sent Off	
Date Received		Date Received	
THIRD REFERENCE		**ISA**	
Date Sent Off		Date Received	
Date Received		Reference No	