



REFERENCES:

State the full name and work address of the two professional references, one of which must be your current or most recent employer:

Reference 1.

Reference 2.

|                |  |                |  |
|----------------|--|----------------|--|
| Name:          |  | Name:          |  |
| Establishment: |  | Establishment: |  |
| Address        |  | Address        |  |
| Post Code:     |  | Post Code:     |  |
| Position Held: |  | Position Held: |  |
| Telephone:     |  | Telephone:     |  |
| Email:         |  | Email:         |  |

EMPLOYMENT HISTORY

Give details of your employment over the last 5 years, all gaps over 3 weeks must be accounted for. Include the month and the year, starting with your current or last job.

|               |  |      |  |
|---------------|--|------|--|
| Position      |  |      |  |
| Establishment |  |      |  |
| Address       |  |      |  |
| Post Code     |  | Tel: |  |
| From:         |  | To:  |  |

|               |  |      |  |
|---------------|--|------|--|
| Position      |  |      |  |
| Establishment |  |      |  |
| Address       |  |      |  |
| Post Code     |  | Tel: |  |
| From:         |  | To:  |  |

|               |  |      |  |
|---------------|--|------|--|
| Position      |  |      |  |
| Establishment |  |      |  |
| Address       |  |      |  |
| Post Code     |  | Tel: |  |
| From:         |  | To:  |  |

|               |  |      |  |
|---------------|--|------|--|
| Position      |  |      |  |
| Establishment |  |      |  |
| Address       |  |      |  |
| Post Code     |  | Tel: |  |
| From:         |  | To:  |  |

REHABILITATION OF OFFENDERS ACT

Due to the nature of the work you are applying for, this post is exempt from the provision of section 4 (2) the rehabilitation of offenders act 1974 by virtue of the rehabilitation of offenders act 1975 (exception) order 1975 applicants are therefore, not entitled to withhold information about convictions which for any other purpose are "spent" under the provisions of the act and in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action. Any information given will be completely confidential and will be considered only in relation to an application for the positions where the order applies and should be entered at the end of any particulars you give in support to this application.

|                                       |  |
|---------------------------------------|--|
| Do you have any criminal convictions: |  |
| If yes please give details:           |  |
| <br><br><br><br>                      |  |

I understand my GP may be contacted in regards to my application, and I may have to incur a cost, as applied by my GP  
*(please tick the box to confirm that you agree to the statement)*

Signed:

Date:

**PLEASE PROVIDE EVIDENCE OF PROFESSIONAL QUALIFICATIONS, IMMUNISATIONS AND MANDATORY TRAINING.**

Have you ever suffered from or been treated for the following? Your medical history will not effect your application.

|  | YES | NO | DETAILS: |
|--|-----|----|----------|
| Heart / circulatory, Hypertension          |     |    |          |
| Diabetes                                   |     |    |          |
| Asthma / Hay fever                         |     |    |          |
| Bronchitis / Pneumonia                     |     |    |          |
| Tuberculosis                               |     |    |          |
| Epilepsy /Dizziness                        |     |    |          |
| Headaches / Migraines                      |     |    |          |
| Psychiatric illness / Depression / Anxiety |     |    |          |
| Dermatitis / Skin sensitivity              |     |    |          |
| Eczema / Psoriasis                         |     |    |          |
| Back injury / back pain                    |     |    |          |
| Hepatitis / Jaundice                       |     |    |          |

Are you registered disabled?                      Yes      No

If yes, registration number:

Are you currently receiving any medication or treatment from your GP?    Yes      No

Details:

Do you have any other physical disability or health concern that may affect your ability to carry out assignments?

Yes      No

Details:

Additional Information:-

Work Specialism / Preference:

- 1.
- 2.
- 3.

Preferred Work Location

- 1.
- 2.
- 3.

Notes:

Bank Details

|  |                                      |
|--|--------------------------------------|
| Sort code:   | Account No:                          |
| Account holders name:  |                                      |
| I authorise <i>Prudent health services</i> to pay my weekly earnings directly into the bank or building society whose details I have given above. I confirm that I will notify in writing of any changes to these details. |                                      |
| Signed:  | <i>Prudent health services</i> Date: |
| If you require to be paid through a UK Limited or Composite company, then the following details are required. N.B. Certificates of registration will be required.  |                                      |
| Company Name   |                                      |
| Company Reg No.  |                                      |
| Company VAT No. (If VAT payments required)   |                                      |
| For OFFICE USE:  | Payroll use:                         |
| Registration use checked by:   | Date set up:                         |
| Signature:   | Signature:                           |

I DECLARE THAT ALL THE STATEMENTS AND PARTICULARS ARE TRUE AND COMPLETE  
(Please tick the box to confirm that you agree to the statement)

SIGNED:

NAME:

DATE:

|  |     |       |         |
|--|-----|-------|---------|
| Have you ever had any problems with your joints, including pain, swelling or stiffness?  |     |       |         |
| Do you have any difficulty in moving rapidly over short distances?   |     |       |         |
| Would you have difficulty looking over either shoulder?  |     |       |         |
| Do you need to wear glasses or contact lenses?   |     |       |         |
| Do you have any difficulty with your eyesight which is not corrected by glasses or contact lenses?   |     |       |         |
| Have you any problems working with Visual Display Units?   |     |       |         |
| Have you any problems working in confined spaces/using lifts?  |     |       |         |
| Do you have any difficulty hearing normal conversation?  |     |       |         |
| Are you taking any medication that makes you dizzy or drowsy?  |     |       |         |
| Do you have a medical condition affected by changing sleeping patterns or affecting day time sleep?  |     |       |         |
| Have you suffered from any alcohol or drug related illness or had an alcohol or drug problem?  |     |       |         |
| Are you having or awaiting any treatment at the moment?  |     |       |         |
| What is the date of your last x-ray?   |     |       |         |
| Are you receiving Medicines, Pills, or Tablets from a doctor or on prescription?   |     |       |         |
| Have you ever suffered from any of the following?  | Yes | No    | Details |
| Heart Problems/Circulatory Illness/Hypertension  |     |       |         |
| High or Low Blood Pressure   |     |       |         |
| Diabetes   |     |       |         |
| Asthma/Hay fever   |     |       |         |
| Bronchitis/Pneumonia/Pleurisy  |     |       |         |
| Tuberculosis   |     |       |         |
| Epilepsy/Fainting Attacks/Blackouts/Fits/Sudden Collapse   |     |       |         |
| Headaches/Migraine   |     |       |         |
| Psychiatric Illness/ Anxiety/Depression  |     |       |         |
| Dermatitis/Skin Sensitivity/Psoriasis/Eczema/Allergies   |     |       |         |
| Back Injury/Back Problems/Back Pains   |     |       |         |
| Recurrent Infections e.g Sore throats/Ear Infections/Eye Infections  |     |       |         |
| Hepatitis/Jaundice   |     |       |         |
| HIV  |     |       |         |
| Tetanus  |     |       |         |
| Typhoid  |     |       |         |
| Any other  |     |       |         |
| I declare the statements are true and complete to the best of my knowledge and belief. I understand that my General Practitioner may be consulted with my prior consent. |     |       |         |
| Signed:  |     | Date: |         |

| DECLARATIONS:              |  |
|----------------------------|--|
| 1.HEALTH                   | <p>I declare that the answers given with 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 my removal from Prudent Health Services LTD I give permission to contact my GP to obtain further information if necessary</p> <p>Signed: _____ Date: _____</p>  |
| 3.TERMS &CONDITIONS        | <p>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 from the Criminal Records Bureau. I undertake to inform Prudent health services should I be convicted of an offence in the future. I undertake to inform Prudent health services if I am engaged through their introduction, including the offer of permanent employment following a temporary assignment. I agree to respect the confidentiality of patients and any other information I may have access to, at all times. I am clear that Prudent health services cannot guarantee assignments and that they have no responsibility to pay for hours not worked no matter the situation. I have read, understood and agree to the conditions of work for temporary nurses, of which I have been given a copy.</p> <p>Signed _____ Date: _____</p> |
| 4.INDUCTION                | <p>I have received a copy of the Induction information letter and can confirm that I am aware that more detailed information on the staff handbook and Policy and procedure can be obtained directly <i>Prudent health services</i></p> <p>Signed: _____ Date: _____</p>   |
| 5.WORKING TIME REGULATIONS | <p>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 <i>Prudent health services</i> not less than three months notice. I understand that my registration with <i>Prudent health services</i> can be terminated at any time following unsatisfactory work reports.</p> <p>Signed: _____ Date: _____</p>  |
| 6.BANK DETAILS             | <p>I have completed my bank details and confirm they are complete and correct. I hereby understand that any incorrect or incomplete details can result in a delay of my payment.</p> <p>Signed: _____ Date: _____</p>  |
| 7.DATA PROTECTION          | <p>I agree that Prudent Health Services LTD retains 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 Data Protection Act.</p> <p>Signed: _____ Date _____</p>  |