Sussex Comfort Care

Job Application form

DOCUMENT REQUIREMENTS CHECKLIST

Name:		Band:		Date:	
STAGE 1 (Video Interview Via Whats app)					
Video Interview	☐				
STAGE 2					
Registration Application:	☐				
Occupational Health Questionnaire	☐				
STAGE 3 (All Personal Documents)					
Evidence of GMC/NMC/ HCPC pin:	☐				
Evidence of Insurance Membership (RCN / UNISON)	☐				
Passport Size Photo:	☐				
Photo ID (Passpport / Right to Work including any visa' s if applicable):	☐				
CV (Full Employment without any gaps)	☐				
Proof of Address x 2 (Utility Bills, Banks Statements, Credit Card Statements):	☐				
National Insurance Number (NI Card/HMRC Letter):	☐				
Immunisations Reports (Blood Reports):	☐				
Qualification (Doctors/Nursing/ AHP Diploma/Degree/All in-house training Certificates)	☐				
References Covering 3 Years x 2	☐				
Mandatory Training Certificate / Practical Training certificate (Every 12 Months)	☐				
Enhanced DBS Check / Update service number: (Every 12 Months)	☐				
LTD : Certificate of Incorporation & Business Bank Statement Joint Employment Scheme: Maxipay	☐				
STAGE 4 (Explain All Express Nursing Policy)					
Explain Uniform Policy:	☐				
Explain ID BADGE Policy:	☐				
Explain Timesheet & Payment Policy:	☐				
Rate Sheet	☐				
Explain Bookings & Availability Process:	☐				

Recruitment Consultant :		Agency Worker Name:	
Sign:		Sign:	
Date:		Date:	

Agency Requirements & Expectation

1. Healthcare Expertise

We are always there to support our clients last minute and at short notice when it matters the most to them, and we recruit only agency workers with UK based hospital experience

Are you authorized to work in the UK?			
Yes	☐	No	☐

2. Professional Registration

We recruit Healthcare professionals registered with GMC, NMC & HCPC and we know to maintain your yearly license there is a fee, hence why we cover the cost on your behalf in supporting us for last minute locum work with our clients nationwide.

Which certification applies to you?									
GMC	☐	NMC	☐	HCPC	☐	HCA	☐	NONE	☐

3. Crucial Experience

We always thrive to recruit only specialist in their field as this would enable us to get candidates with right skills and attitude to be deployed at short notice to support our clients nationwide.

How much experience do you have?							
< 6 Months	☐	6-12 Months	☐	1-5 Years	☐	> 5 Years	☐

4. Always On Call

We are always there to support our clients for last minute and short notice shifts turning into long term bookings, and we make sure all our agency workers are getting paid the highest rates in the market for their commitment to support our clients last minute when it matters the most!

Are you able stay on call for us and pick up shifts less than 4 hours' notice?			
Yes	☐	No	☐

5. Going the Extra Mile

Since we supply healthcare professionals nationwide, there are opportunities that our agency worker might have to travel but we always ensure the travel cost is covered.

*Travel expenses are paid at 25 pence per mile for journeys up to 200 miles and at 30 pence for each additional mile over 201 miles including bridge tolls and congestion charges. Reasonable public transport costs will be paid for the return journey. Receipts for all incidental travel costs must be provided.

Will you be happy to travel up to 80-100 miles round trip to support clients at short notice or Long term bookings?			
Yes	☐	No	☐

6. DBS

All prospective workers require a current, valid Disclosure (DBS) as part of the recruitment process. You will either need to have ongoing registration with the **DBS Update Service** or be happy to complete a new check with us.

Do you have a current Enhanced level DBS, checked against the child and adult workforce registered on the annual update service?			
Yes	☐	No	☐

Please Note: If you do not have DBS we can process one for you for £68.00

7. Uniform Policy

We expect all our workers to wear your provided branded uniform whilst on placement (unless otherwise specified by the client

You will need to order Uniform from our website Please tick 'Yes' to confirm you are aware of and will adhere to this requirement.			
Yes	☐	No	☐

8. Professional Conduct

Are you currently being investigated by your employer, the GMC, NMC, HCPC or any other regulatory body, or are undergoing any form of disciplinary or suspension?			
Yes	☐	No	☐

9. COVID Vaccination Status

Although the Agency doesn't restrict registration or work based on vaccination status, some Client's may only accept vaccinated workers.

Please record your COVID vaccination status here					
Triple Vaccinated	☐	Double Vaccinated	☐	Exempt	☐

10. Mandatory Training

All applicants must have completed Mandatory Training within the last 12 months.

Have you completed this training within the last 12 months?			
Yes	☐	No	☐

Please Note: if you do not have a certificate or modules are missing at the time of registration, We offer e-learning mandatory training for £35.00 to complete within 5 days. According to our yearly support package to all our healthcare professionals we offer free yearly training thereafter.

11. My Yearly Support Package

- We offer free GMC / NMC / HCPC Yearly Renewal
- We offer free Revalidation support with our clinical governance
- We offer free Yearly Mandatory Training
- We offer free Yearly Appraisal too!

We believe in giving back to the heroes who has always supported us when it matters the most.
You simply have to work 25 shifts in the year between your last NMC renewal and your upcoming renewal and keep your compliance up to date.

12. Referral Package

Refer a Friend and Earn ££££ T&C apply Earn £ 300 when the referral has completed 10 shifts with us.. T&Cs apply					
No.	**Name**	**Speciality**	**Phone Number**	**E-mail**	**Earn**
1.					£ 300
2.					£ 300
3.					£ 300
4.					£ 300
5.					£ 300

POSITION APPLYING FOR:		BAND:	

YOUR PERSONAL DETAILS:	Referred By : Name / Number
Title: ☐ Mr. ☐Mrs. ☐ Ms. ☐ Miss ☐ Other	Email Address:
Surname:	Do you hold a current driving licence: ☐Yes ☐No
First Name:	Date of Birth:
	Nationality:
Any other names you may be known as including Maiden name:	National Insurance No:
	Next of Kin's Name:
Address:	Next of Kin's Address:
Postcode: Date Moved In:	Next of Kin's Telephone No:
Day Time Telephone No	Next of Kin's Mobile Phone No:
Mobile Phone No:	
Have you changed your surname since birth? ☐Yes ☐No	Year From To Year
Have you changed your nationality since birth? ☐Yes ☐No	Year From To Year
Driving licence number	Valid From: Valid Till:
Passport No (If applicable)	Date of Issue: Country of Issue:

YOUR PROFESSIONAL REGISTERATION DETAILS	PREVIOUS ADDRESS A (if above is less than 5 years)
GMC / NMC/ HCPC Pin Number:	Address:
GMC / NMC/ HCPC Expiry Date:	Postcode:
Revalidation Expiry Date:	Time lived at address (MM/YY):
Indemnity Insurnace:	
Membership Number:	

YOUR CLINCAL SETTING PREFERENCES: NURSING TEAM		
☐ A&E	☐ Nursing Home	☐ Theatres - Anesthetics
☐ CCU	☐ Other	☐ Theatres - Endoscopy
☐ Chemotherapy	☐ Paediatrics	☐ Theatres - Recovery
☐ Community	☐ Practice Nurse	☐ Theatres - Scrub
☐ Community Complex Care	☐ Prisons	☐ Theatres - Circulating
☐ District Nurse	☐ Renal Dialysis	☐ Theatres - Other
☐ HDU	☐ SCBU	☐ Wards
☐ ITU	☐ School Nurse	
☐ NICU	☐ Theatres – 1st Assistant	
YOUR CLINCAL SETTING PREFERENCES: DOCTORS TEAM		
☐ A&E Doctors	☐ Obstetrics and Gynaecology Doctors	☐ Psychiatry Doctors

☐ Anaesthetic Doctors	☐ Paediatric Doctors	☐ Radiology Doctors
☐ General Practitioners	☐ Intensive Care Units	☐ Surgical Doctors
☐ Medicine Doctors	☐ General Anaesthetics	
YOUR CLINCAL SETTING PREFERENCES: AHP TEAM		
☐ Dietetics	☐ Occupational Therapy	☐ Physiotherapy
☐ Podiatry	☐ Radiography and Sonography	☐ Speech and Language Therapy

YOUR RIGHT TO WORK DETAILS (Your Current Visa Status (Please tick one):		
I am a British Citizen:	☐	If 'Other", please detail below:
I have Permanent Residency:	☐	
I have indefinite leave to remain:	☐	
I am a European national:	☐	
Other: ☐	☐	

EMPLOYMENT HISTORY	
• Three full years of employment history, up to and including todays date, must be added before submitting. • If there are any gaps please explain.	

Employers Name and Address:			
Position/Band:			
Ward Name:			
Type of Unit:			
Date From:		Date To:	
I currently work here: ☐			
Employers Name and Address:			
Position/Band:			
Ward Name:			
Type of Unit:			
Date From:		Date To:	
Reason for leaving:			
Employers Name and Address:			
Position/Band:			
Ward Name:			
Type of Unit:			
Date From:		Date To:	
Reason for leaving:			

EDUCATIONAL DETAILS			
University Name	**Course**	**Dates (from/to)**	**Qualification Awarded**

YOUR REFERENCE DETAIL

- Please supply details of 2 professional clinical referees, we can only accept work/professional email address.
- One MUST be from your present employer or more recent and must be a senior band (grade) to yourself.
- You should have worked for any referee for at least 1 month where permissible. Your references must cover a minimum of 3 year period.
- Please be advised that we will contact your referees as soon as we receive your application unless otherwise advised.

REFEREE 1	REFEREE 2
Name:	Name:
Position:	Position:
Mobile number:	Mobile number:
Work Email Address:	Work Email Address:
In what capacity was the referee known to you?:	In what capacity was the referee known to you?:
How long has this person known you?: Date From: Date To:	How long has this person known you?: Date From: Date To:

EQUAL OPPORTUNITIES MONITORING

We are an equal opportunity employer and positively encourage applications from suitably qualified and eligible candidates regardless of sex, race, disability, age, sexual orientation, or religion or belief. To enable us to improve and monitor our employment processes, please complete the section below and note that this information is confidential and will be used only for the purpose of monitoring.

SEX: Please tick the appropriate box.

☐ Male ☐ Female ☐ Transgender ☐ Undisclosed

DISABILITY:

Do you consider yourself to be a disabled person? ☐ Yes ☐ No ☐ Undisclosed

If yes, please give brief details of your disability:

SEXUAL ORIENTATION:

☐ Bisexual ☐ Heterosexual ☐Homosexual ☐Undisclosed ☐ Other, please specify:

RELIGION or BELIEF:

☐ Anglican ☐ Catholic ☐Other Christian ☐Protestant ☐ Buddhist ☐ Jewish ☐ Muslim ☐ Sikh ☐ Hindu ☐ Other, please specify:

ETHNIC ORIGIN:

WHITE:	☐ English ☐ Scottish ☐Welsh ☐ Irish ☐ Other, please specify:
MIXED:	☐ White & Black Caribbean ☒White & Black African ☐White & Asian ☐ Other, please specify:

ASIAN:	☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Other, please specify:
BLACK:	☐ Caribbean ☐ African ☐ Other, please specify:
CHINESE:	☐ Chinese Other, please specify:
OTHER:	Please state:
Prefer not to answer this question ☐	
NATIONALITY:	

DOCTOR / NURSE / AHP PROFESSIONAL INDEMNITY SELF DECLARATION

The need to have in place an indemnity arrangement is a mandatory requirement of the GMC/ NMC / HCPC Code.It is the professional responsibility of each healthcare professional to ensure that you have cover which is appropriate to your role and scope of practice and its risks. If you have personal cover in place it must be relevant to the risks involved in your practice, so that it is reasonably sufficient in the event that a claim is successfully made against you. You are not required to provide a copy of your documents for your indemnity arrangement when you self declare. However, maintaining good records of your indemnity arrangement is a legal requirement of the GMC/ NMC / HCPC Code. If you practice without cover you will be breaking the law, even though you only have to sign the declaration you must have cover in place at all times. We may undertake compliance checks, identification of failure to have the cover in place once you have signed a self declaration will result in referral to the GMC/ NMC / HCPC.

DECLARATION

I GMC/ NMC / HCPC PIN:

Declare that I have appropriate professional indemnity in place to cover the entirety of my professional scope of practice.

I understand that signing this declaration and failing to have the appropriate cover in place at all times would result in me being personally liable for any claims.

SIGNED:	DATE:

EXPRESS NURSING PAYMENT SETUP (Please choose from one of the following payment options A, B, C)		
A – Limited Company	I am Self-Employed through a limited company and would like to be paid into my business acount	☐
B – Limited Company	I am Self-Employed and have a Unique Tax Reference (UTR) Number, NOT through a limited company	☐
C – Limited Company	I would like to be paid via Joint Emploment Scheme: Oribital/TJW (Expresss Nursing Payroll)	☐

UTR Number:		If company name:	
NI Number:		Company number:	
Bank Account name:		Is the company VAT Registered:	
Account Number:		Your position within the company:	
Sort Code:		Companies registered address:	
Name of the bank:			

OCCUPATIONAL HEALTH MEDICAL QUESTIONNAIRE
(NEW STARTER CLINICAL FORM)

CONFIDENTIAL

Personal Information			
Title	Surname	First names	DOB
Home Tel:		Work Tel:	Mobile:
		GP Address:	

Medical History		
All staff groups complete this section	**Yes**	**No**
Do you have any illness/impairment/disability (physical or psychological) which may affect your work?	☐	☐
Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?	☐	☐
Are you having, or waiting for treatment (including medication) or investigations at present?	☐	☐
Do you think you may need any adjustments or assistance to help you to do the job?	☐	☐

Medical History (continued)		
Have you suffered from any of the following?	**Yes**	**No**
methicillin resistant staphylococcus aureus (**MRSA**)	☐	☐
clostridium difficile (**C-Diff**)	☐	☐

If you have indicated yes to any of the above questions you must provide further details in additional information section, failure to do so will result in the form being returned/rejected.

Additional Information (If you have answered yes to any questions above please provide additional information below, including dates, treatment and details of condition)

Chicken Pox or Singles		
Have you ever had chicken pox or shingles?		
Yes	**No**	**Date**
☐	☐	

BBV (Blood Borne Virus)	
Have you ever come into contact with any BBV's? Including Needle Stick Injuries?	Yes ☐ No ☐

Tuberculosis		
Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2016)	**Yes**	**No**
Have you lived continuously outside the UK or had an extended holiday outside the UK in the last year?	☐	☐
If you answered YES to the above, please list all the countries that you have lived in/visited over the last year, including holidays and vacations. This MUST include duration of stay and dates or this form will be rejected.		
Have you had a BCG vaccination in relation to Tuberculosis?	☐	☐
If you answered yes please state when? Date		

Tuberculosis Continued		
Do you have any of the following:	**Yes**	**No**
A cough which has lasted for more than 3 weeks	☐	☐
Unexplained weight loss	☐	☐
Unexplained fever	☐	☐
Have you had tuberculosis (TB) or been in recent contact with open TB	☐	☐

Additional Information (If you have answered yes to any questions above please provide additional information below)

Immunization History								
Have you had any of the following immunisations						**Yes**	**No**	**Date**
Triple vaccination as a child (Diptheria / Tetanus / Whooping cough)						☐	☐	
Polio						☐	☐	
Tetanus						☐	☐	
Hepatitis B (If Yes is ticked please give dates below)						☐	☐	
Course	1		2		3			
Boosters	1		2		3			

Proof of Immunity (Please send the following)	
Varicella	You must provide a written statement to confirm that you have had chicken pox or shingles however we **strongly advise** that you provide serology test result showing varicella immunity.
Tuberculosis	We require an occupational health/GP certificate of a positive scar or a record of a positive skin test result **(Do not Self Declare)**
Rubella, Measles & Mumps	Certificate of **"two"** MMR vaccinations or proof of a positive antibody for Rubella and Measles
Hepatitis	You must provide a copy of the most recent pathology report showing titre levels of 100lu/l or above
Proof of Immunity (Please send the following) EPP Candidates Only	
Hepatitis B Surface Antigen	Evidence of a negative Surface Antigen Test. (Inc. 'e' antigen and DNA viral loads if applicable. Report must be an identified validated sample. (IVS)
Hepatitis C	Evidence of a negative antibody test (Inc. Hepatitis C RNA/PCR if applicable) Report must be an identified validated sample. (IVS)
HIV	Evidence of a negative antibody test. (Inc. DNA viral loads if applicable) Report must be an identified validated sample. (IVS)

Exposure Prone Procedures		
Will your role involve Exposure Prone Procedures	**Yes** ☐	**No** ☐

The General Data Protextion Regualtion (GDPR) (EU) 2016/679

All information supplied by you will be held in confidence by Healthier Business UK Ltd. Records will be retained electronically in accordance with best practice and the requirements of the General Data Protection Regulations at which time it may be subject to audit. Your data may also be cross referenced should you have registered with other clients of Healthier Business UK Ltd. Your personal data may be required to be seen by an occupational health advisor or physician; however it will not be shown, nor their contents shared with anyone - including Managers, Human Resources Advisors, GP's, Specialists or third party's - without your explicit consent. You have the right of erasure (the right to be forgotten), refusal of consent and withdrawal of consent without detriment (withdrawal of consent can be exercised at any stage of the process). The only exceptions to this may be a court order for release of records in a judicial dispute or where there is a public responsibility obligation. Further information regarding your rights under GDPR can be found on the following: https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/individual-rights/

Consent

Consent is a process rather than a one off decision, for consent to be valid, it must be voluntary and informed. You have the right to withdraw your consent at any stage of the process, either verbally or in writing. Further information regarding consent is available on the 'Candidate Screening Leaflet'.

All staff groups complete this section	**Yes**	**No**
Do you consent to this questionnaire and your immunisation reports being assessed by an Occupational Health Advisor for the purpose of providing a Fitness to Work Certificate?	☐	☐
Do you consent to our Occupational Health Advisors speaking with you regarding any declaration you may have made relating to your medical history?	☐	☐
Do you consent to our Occupational Health Advisors making recommendations to your employer/agency to assist with your ability to carry out your perspective role?	☐	☐

Declaration

I will inform my employer if I am planning to or leave the UK for longer than a three month period to enable a reassessment of my health to be conducted on my return.

I declare that the answers to the above questions are true and complete to the best of my knowledge and belief.

Name	Signature	Date