MEDICAL CARE SERVICES LTD

Candidate Registration Form

About You, Your Work and Payment Details

Please write clearly in BLOCK CAPITALS using black ink

ABOUT YOU			
Surname		Title (Mr/Mrs/Miss/Ms)	
First Name(s)		Male Female	
Marital status		Date of Birth	
National Insurance No			
Current Address Post Code			
Mobile Phone		Home Phone	
E-mail			
Do you drive	Yes No	How do you usually travel to work	

NEXT OF KIN			
Name of Next of Kin		Relationship	
Phone Number			
Your Signature		Date	

ABOUT YOUR WORK					
Job Title					
Speciality 1		Speciality 2		Speciality 3	
Current Place of Work		Full Time Part Time Days Nights			

YOUR PAYMENT DETAILS		
Name of Bank/Building Society		
Account Name		Personal

Branch Address Post Code			
Account No		Sort Code	- -

Your Training, Qualifications, Appraisals and References

Please enclose, with your application a copy of your registration and membership card

Nurses	NMC Number		RCN Number		Band	
ODPS	HPC Number		This does not apply to HCA's			

MANDATORY TRAINING

Please tick if you have completed the following training within the last 12 months

Please enclose copies of your training certificates

Moving and Handling		Basic Life Support		Intermediate Life Support		Advanced Life Support	
Complaints Handling		Handling Violence and Aggression		Fire Safety		COSHH	
RIDDOR		Caldecott Protocols		Data Protection		Infection Control	
Lone Worker Training		Equality & Inclusion		Food Hygiene (where required to handle food)		Personal Safety (Mental Health &Learning Dis')	
Resuscitation of the New-born (Midwifery)		Interpretation of Cardiotocograph Traces (Midwifery)		Practical			

REFERENCES

Please supply us with two professional referees. One must be from your present or most recent employer and must be a senior grade to yourself and you must have worked for that person for a period of not less than three months duration.

1. Name			Position		
Work Address Postcode					
Work E-mail		Tel		Fax	
2. Name			Position		
Work Address Postcode					
Work E-mail		Tel		Fax	

Your DBS status and Uniform

Please send a copy of your most recent DBS Disclosure (formally known as CRB)

Current DBS Disclosure (formally known as CRB)	Yes No	Clear	Yes No	
Issue Date		Disclosure Number		
Is this certificate registered with the update service	Yes No			

All applications who cannot provide a registered DBS or full immunisation record will be required to complete at their own cost. **Rapid Medical Recruitment services ltd** will facilitate Mandatory Training updates however costs and cancellations outside of 48 hours and late attendances will be charged to the candidate.

Candidates will be required to purchase uniform if required at the cost of £10 this will be deducted from your timesheet once you have started working through us. Please fill in the box below stating your uniform size and quantity.

Your Work History

Please ensure you complete this section even if you have a CV. Employment history should be recorded on an Application Form which is signed. Please ensure that you leave no gaps unaccounted for and it covers full work history including your education. Please use extra paper if required.

From	/ /	To	/ /	Employer	
Title of Post				Grade	

From	/ /	To	/ /	Employer	
Title of Post				Grade	

From	/ /	To	/ /	Employer	
Title of Post				Grade	

From	/ /	To	/ /	Employer	
Title of Post				Grade	

Your Declaration

WORKING TIME REGULATIONS

For the purposes of the Working Time Regulations 1998 (as amended) I, consent to work in excess of an average of 48 hours per week, averaged over 17 weeks. I understand that I may withdraw this consent by giving my employer not less than three months' notice at any time.
In addition, I also consent to work more than the maximum number of hours permitted to work at night under the directive.

Signed		Print Name		Date	

HEALTH DECLARATION

All applicants must complete the enclosed health questionnaire to enable us to establish your fitness for work.

PERSONAL DECLARATION

I hereby confirm that the information provided on my application is correct and true to the best of my knowledge and that I have not withheld any information that should be considered when offering me work.

I understand that providing false or inaccurate information may result in the termination of any placement.

CONFIDENTIALITY

I hereby declare that at no time will I divulge to any person, nor use for my own or any other person's benefit, any confidential information in relation to the Client or the Company Rapid Medical Care Services ltd or in relation to any of their business affairs, employees, transaction, or finances which I may acquire during the term of my agreement with the company (Rapid Medical Care Services) under the Terms of Engagement. Applicants are therefore required to give information about convictions which for other purposes are "spent" under the provisions of the Offenders Act (1974) (Exception) Order 1975 apply.

1	Do you have any convictions, cautions, or bind overs? If yes, please give details...	Yes	No
2	Have you ever had disciplinary action taken against you? If yes, please give details...	Yes	No
3	Are you at present the subject of criminal charges or disciplinary action? If yes, please give details...	Yes	No
4	Do you agree for Rapid M.C.to check the status of your DBS by performing an online check at any time during your employment? (For candidate registered on the update service only)	Yes	No
5	Do you consent to Rapid M.C. requesting a police officer (DBS) or any appropriate references on your behalf?	Yes	No

RIGHT TO WORK IN THE UK

Please complete this form, regardless of your nationality, as it is a legal requirement. If you are an overseas national or require a work permit to work in the UK, please include copies of supporting documentation.

Your entitlement for working in the UK is based upon what status:

EU Citizen		Spouse of an EU Citizen		Work Permit	
Permit-free Visa		Right of Abode in the UK		Admitted to UK as Doctor Prior to 1985	

HEALTH & SAFETY

Each agency worker has a responsibility at the start of their first shift to become familiar with the Client's general policies including, in case of emergency calls, Fire Policy and the Lone worker Policy.

I.D. AND INDEMNITY VERIFICATION

All Nurses need to have in place an indemnity arrangement as a mandatory requirement of the NMC Code.

Registration Form Declaration

PLEASE READ BEFORE SIGNING

I declare that by signing this form I am agreeing to declarations 2-8. I am stating that I am legally entitled or allowed to work in the United Kingdom, with or without necessary permission from the Home Office or any other relevant authority. If I have secured permission to work, I have included copies of all documentation. I also acknowledge that if it is found that I am working without the relevant permission, my employment will be terminated with immediate effect and all details will be passed to the relevant authorities.

I agree that Rapid Medical Care Services retain the right to hold this registration form and any other data required to process it and pass to any authorised third party and the details held within.
I also agree to use all reasonable efforts to assist to comply with Data Protection Act 1998.
In addition, I also confirm that all the information provided is true and accurate, and that I have received and agreed to Rapid Medical Care Services terms of engagement and staff handbook.

PERSONAL INFORMATION			
Title	Surname	First names	DOB

Home Tel		Work Tel		Mobile	
Home Address		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? If your answer is yes, please providing further details of the condition, treatment and dates		
Do you think you may need any adjustments or assistance to help you to do the job		

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

TUBERCULOSIS		
Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006)	Yes	No
Have you lived continuously in the UK for the last 5 years		

If you answered no above, please list all of the countries that you have lived in over the last 5 years		
Have you had a BCG vaccination in relation to Tuberculosis		
If you answered yes, please state when Date		
Do you have any of the following		
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)

CHICKEN POX OR SHINGLES			
	Yes	No	Date
Have you ever had chicken pox or shingles			

IMMUNISATION HISTORY			
Have you had any of the following immunisations	Yes	No	Date
Triple vaccination as a child (Diphtheria / 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 Measles & Mumps
Hepatitis B	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 Report must be an identified validated sample. (IVS)
Hepatitis C	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)
HIV	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)

EXPOSURE PRONE PROCEDURES		
	Yes	No
Will your role involve Exposure Prone Procedures		

DECLARATION

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

Signed		Print Name		Date	

Thank you for completing your registration form

✓ Book an appointment to register in the office

✓ Get yourself compliant within two weeks

✓ We run a weekly payroll service.

✓ Do you know if you refer your friends, we will pay you £100 per person? Many of our candidates are earning100's through referrals every month, why not start today?"

Referral 1. Name		Telephone Number	
Referral 2. Name		Telephone Number	
Referral 3. Name		Telephone Number	

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