Nurses Friend Application Form

All Information Confidential

Forenames:	Gender :
Surname:	Male/Female
Address:	
Post Code:	

Maiden Name:

Name of Next of Kin or Person to Contact in Emergency:
Address and Telephone No:

Date of Birth:

Marital Status:

N.I. No.

Nationality:	Religion:

Phone No.'s & Email
Home:
Mobile:
Email:

Employment History

Please give details of previous employment covering a period of 5 years with all gaps explained

Date	Name & Address of Employer	Reason for Leaving
From To Position		
From To Position		
From To Position		
From To Position		

Nursing qualification: please list most recent qualifications first:

Year:	Registered qualification	Register part	College:
(Qualified Nurses only)	UKCC PIN:		Expiry Date:

References

Please give the name of 2 referees who have known you in a professional capacity; one of whom must be your most recent employer

Name of most recent employe	Address(Including Post Code)
1)	
Title / position of referee	Telephone Number:
Name of second referee: 2)	Address(Including Post Code)
Years Known	Telephone Number:

In the space below please give an account of your experience to date, and what attracts you to agency nursing:

Please list with dates any training you have undergone :

Languages

Please list the languages in which you are fluent (including your Mother tongue).
Please include any sign languages.

Language	Please tick if fluent		
	Speech	Reading	Writing

DECLARATION OF HEATLH

If the answer is yes to any of the quetions in this section, please give full details in the space provided of the dates, duration and outcome of the illness or condition. If Nurses Friend has any concerns about your fitness to work, any offer of Membership may be subject to a satisfactory medical report. Please note: you must inform Nurses Friend immediately if your health changes significantly

Have you ever had: (Please answer yes or no)	**Additional Information**
Back problems	____________________
Blackouts, fits or giddiness	____________________
Bladder or kidney problems	____________________
Chest complaint (eg. tuberculosis, asthma, bronchitis)	____________________
Chest pain, heart condition or raised blood pressure	____________________
Dermatitis or skin trouble	____________________
Diabetes, thyroid or other gland trouble	____________________
Digestive or bowel disorder?	____________________
Mental illness for which you have recieved medication (eg. depression or psychosis)	____________________
Rheumatism or arthritis	____________________
Typhoid, paratyphoid or dysentry	____________________
Varicose veins	____________________
Any accident, operation or illness not listed above	____________________
Have you any reason to believe you may be infected by any communicable disease	____________________
Any physical disabilities including defect of sight or hearing	____________________

Please give date of immunisation/ vaccination for:-

Do you have a GP certificate of vaccinations? **YES** **NO**

Hepatitis B __________ Next blood test due: __________

Poliomylitis __________

Rubella (German Measles) __________

Tetanus __________

Tuberculosis BCG __________

Other ______________________________

REHABILITATION OF OFFENDERS ACT 1974

By virtue of the Rehabilitation of Offenders Act 1974 (Exceptions) (Amendments) Order 1986, the provisions of section 4.2 of the Rehabilitation of Offenders Act 1974 do not apply to any employment which is concerned with the provision of health services and which is of such a kind as to enable the holder to have access to the persons in receipt of such services in the course of his or her duties. Your answer to the following question should include any 'spent' convictions.

	YES	NO
Have you ever been convicted of a criminal offence? If 'YES' please give details on a separate sheet.		
Are you willing to obtain a CRB check?		

Do you give permission for your information to be shared with:

	YES	NO
The UK Border & Immigration Agency		
Our Regulatory Body (CQC)		
Any other outside Audit Team		

If NO please give a brief explanation for your reason as this may effect your suitability for employment with Nurses Friend.

Experienced in: Please state which of the following you have experience in.

Mental Health	YES/NO	Elderly	YES/NO
LD Challenging	YES/NO	Elderly Mentally Ill	YES/NO
LD Profound	YES/NO	Brain Injured	YES/NO
Homecare	YES/NO	Live - in care	YES/NO
Support work	YES/NO		

Transport: Do you have your own transport? YES/NO

I declare that all the information given is true and I understand that any false or misleading information may result in my removal from the Nurses Friend register of members.

Signed: ________________________________ **Date:** ___________