



Offering specialised Healthcare to local communities

**PERSONAL INFORMATION**

RGN	RMN	H.C.A	RCN	MIDWIFE
ODP	AHP	SCRUB	Support Worker	D/NURSE

**PERSONAL DETAILS:**

Full Name	Nationality
Address	EU Citizen
	Visa Status
	NI Number
Post Code	HPC Registration
Contact No	Expiry Date
Home:	NMC Pin no
Mobile:	Expiry Date
Work	CPS Registration
Email	Expiry Date
	RCN / Union no
Marital Status	Other
D.O.B	Expiry Date

**NEXT OF KIN:**

Name:	Address:
Phone no:	
Relationship:	Postcode:

**MEDICAL INFORMATION:**

GP's Name:

Address:

Postcode:

Phone no:

**EMPLOYMENT HISTORY**

Please provide 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:

## **REFEREES:**

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.**

Name:  
Establishment:  
Address

Post Code:  
Position Held:  
Telephone:  
Email:

### **Reference 2.**

Name:  
Establishment:  
Address

Post Code:  
Position Held:  
Telephone:  
Email:

## **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:**                      Yes                      No

If yes please give details:

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.**



**BANK DETAILS:**

Sort code:

Account No:

Account holders name:

I authorise Bright Days Care to pay my weekly earnings directly into the bank or building society whose details I have given above. I confirm that I will notify Bright Days Care in writing of any changes to these details.

**Signed:**

**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:**

	Yes	NO	Details
Have you ever had any difficulties with your joints, including pain, swelling or stiffness?			
Do you struggle in moving rapidly over short distances?			
Would you have trouble watching over either shoulder?			
Do you require glasses or contact lenses?			
Do you struggle with your eyesight which is not corrected by glasses or contact lenses?			
Do you have any problems working with Visual Display Units?			
Do you have any difficulties working in confined spaces/using lifts?			
Do you have any hearing difficulties?			
Do you take any medication that causes you to become drowsy or dizzy?			
Do you have a medical condition that may be 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 date was your last x-ray?			
Are you receiving Medicines, Pills, or Tablets from a doctor or on prescription?			
<b>Have you ever suffered from any of the following?</b>	<b>Yes</b>	<b>No</b>	<b>Details</b>
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			
<b>I declare the statements true and complete to the best of my knowledge. I understand that my General Practitioner may be consulted with prior consent.</b>			
<b>Signed:</b>		<b>Date:</b>	

**DECLARATIONS:****1.HEALTH**

I declare that all answers with this Declaration of Health on this form are true & complete to the best of my knowledge. I also understand that making false statements or failure to declare health problems could lead to my removal from First Star Agency. I give Bright Days Care Limited permission to contact my GP to obtain further information if necessary

**Signed:****Date:****3.TERMS &CONDITIONS**

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 Bright Days Care should I be convicted of an offence in the future. I undertake to inform Bright Days Care immediately 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 Bright Days Care 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.

**Signed****Date:****4.INDUCTION**

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 from Bright Days Care Limited

**Signed:****Date:****5.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 Bright Days Care not less than three months notice. I understand that my registration with Bright Days Care Limited can be terminated at any time following unsatisfactory work reports.

**Signed:****Date:****6.BANK DETAILS**

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.

**Signed:****Date:****7.DATA PROTECTION**

I agree that First Star Agency 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.

**Signed:****Date:**

**CRB DISCLOSURE**

Position: \_\_\_\_\_

Title: \_\_\_\_\_ Mr / Mrs / Ms / Miss / Other:

Surname:

Forename (s):

Surname at birth (if  
different) :

Forename at birth (if  
different) :

***If you have been known by any other name please detail below***

Known Surname:

Used  
from: YYYY

Known by Forename(S) :

Used  
from: YYYY

***Address History***

Current Address:

Postcode:

At current address  
since: MMYYYY

Previous Address (if less than  
5 years):

Postcode:

At current address  
since: MMYYYY

Previous Address (if less than  
5 years):

Postcode:

At current address  
since: MMYYYY

***Additional information***

Date of Birth:

DDMMYYYY

Gender:

M / F

Town of Birth:

Nationality:

NI Number:

Telephone number:

Do you have non-spent  
convictions

Yes / No

*Passport number:*

*DOB:*

*Nationality:*

*Issue Date:*

*Driving license no:*

*Issue date:*