**APPLICATION PACK**

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| **PERSONAL DETAILS** | | | | | | | | |
|  | | | | | | | | |
| TITLE | | Select your title from the list. | | | | | | |
| FIRST NAME | | Enter your first name. | | | | | | |
| PREFER TO BE KNOWN AS | | Enter what name you would like to be known as. | | | | | | |
| SURNAME | | Enter your surname | | | | | | |
| DATE OF BIRTH | | Select your date of birth. | | | | | | |
| TELEPHONE / MOBILE NUMBER | | Enter the best number for us to contact you. | | | | | | |
| EMAIL ADDRESS | | Enter your preferred email address for us to contact you. | | | | | | |
| ADDRESS LINE 1 | | Enter your street name. | | | | | | |
| ADDRESS LINE 2 | | Enter your Town / City. | | | | | | |
| POST CODE | | Enter your post code. | | | | | | |
| NATIONAL INSURANCE NUMBER | | Enter your National Insurance number. | | | | | | |
| DO YOU HAVE A FULL DRIVING LICENCE | | YES |  | NO |  | | | |
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| **REFERRALS – YOUR INTRODUCTION** | | | | | | | | |
|  | |  | | | | | | |
| HOW DID YOU HEAR ABOUT US? | | Select how you heard about us. | | | | | | |
| IF REFERRED, PLEASE LET US KNOW BY WHOM | | Enter name of person that referred you. | | | | | | |
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| **REFERRALS – RECOMMENDATIONS** | | | | | | | | |
| *If you know anyone who would be interested in working with us, please include their details below and request more information on our referral fee structure* | | | | | | | | |
| NAME | Enter name of your referral. | | | | GRADE | Enter grade of your referral. | | |
| TELEPHONE NUMBER | Enter contact tel for your referral. | | | | EMAIL ADDRESS | Enter contact email for your referral. | | |
|  |  | | | |  | |  |
| NAME | Enter name of your referral. | | | | GRADE | Enter grade of your referral. | | |
| TELEPHONE NUMBER | Enter contact tel for your referral. | | | | EMAIL ADDRESS | Enter contact email for your referral. | | |
|  |  | | | |  | |  |
| NAME | Enter name of your referral. | | | | GRADE | Enter grade of your referral. | | |
| TELEPHONE NUMBER | Enter contact tel for your referral. | | | | EMAIL ADDRESS | Enter contact email for your referral. | | |

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| **NEXT OF KIN** | | | | | | | |
|  | |  | | | | | |
| FULL NAME | | Enter the full name of your next of kin. | | | | | |
| RELATIONSHIP TO YOU | | Select their relationship to you from the list. | | | | | |
| TELEPHONE NUMBER | | Enter the best contact number to contact your next of kin. | | | | | |
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| **RIGHT TO WORK** | | | | | | | |
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| DO YOU HOLD A BRITISH / EU PASSPORT | | YES | |  | NO |  | |
| NATIONALITY | | Enter your Nationality. | | | | | |
| PASSPORT NUMBER | | Enter your passport number. | | | | | |
| PASSPORT EXPIRY DATE | | Entire the expiry date for your passport document. | | | | | |
| I AM ELIGIBLE TO WORK IN THE UK AND DO NOT REQUIRE A WORK PERMIT | | YES | |  | NO |  | |
| I AM ALREADY IN POSESSION OF A WORK PERMIT TO LEGALLY WORK IN THE UK | | YES | |  | NO |  | |
| IF OTHER PLEASE SPECIFY | | Specify in as much detail as possible any other information in regards to your eligibility to work in the UK. | | | | | |
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| **EDUCATION HISTORY** | | | | | | | |
| EDUCATION | COURSE / SUBJECT | | | | | | ISSUING BODY: NAME OF  COLLEGE / UNIVERSITY / ETC |
| DEGREE / DIPLOMA | Specify the course or subject of your qualification. | | | | | | Confirm the name of the issuing organisation. |
| TRAINING AND CPD | Specify the details of your training of CPD. | | | | | | Confirm the name of the issuing organisation. |
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| **PROFESSIONAL DETAILS** | | | | | | | |
|  | | | | | | | |
| PROFESSIONAL BODY NUMBER:  NMC / HCPS / GPC | | Enter your unique relevant professional body number. | | | | | |
| EXPIRY DATE | | Select date of expiry. | | | | | |
| SPECIALITY | | Confirm any additional speciality information. | | | | | |
| ARE THERE ANY ISSUES OR INVESTIGATIONS OUTSTANDING ON YOUR NMC / HCPC / GPC | | YES | |  | NO |  | |
| ONGOING / OUTSTANDING ISSUES OR INVESTIGATIONS DETAILS | | Specify in as much detail as possible information in regards to the ongoing issue. | | | | | |
| NVQ LEVEL / CARE CERTIFICATE(S) | | Specify details on your NVQ / Care certification qualifications. | | | | | |
| HCA QUALIFICATION(S) | | Specify details on your HCA qualifications. | | | | | |

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| **REVALIDATION (NURSES ONLY)** | | | | | | | | | |
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| HAVE YOU COMPLETED YOUR REVALIATION? | | YES |  | NO |  | | DATE (IF YES) | Enter date revalidation done. | |
|  | |  | | | | | DATE (IF NO) | Enter date of next revalidation. | |
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| **YOUR PROFESSIONAL EXPERTISE** | | | | | | | | | |
| *Please tick the relevant boxes with the clinical areas you have worked in* | | | | | | | | | |
| ACCIDENT & EMERGENCY |  | | | | | HOMECARE | | |  |
| LEARNING DISABILITY |  | | | | | RECOVERY | | |  |
| CARDIAC |  | | | | | HOSPITAL | | |  |
| CHEMOTHERAPY |  | | | | | CLINICS | | |  |
| MENTAL HEALTH |  | | | | | DIAGNOSTIC IMAGING X-RAY | | |  |
| COMMUNITY |  | | | | | MIDWIFERY | | |  |
| ENDOSCOPY |  | | | | | SURGICAL | | |  |
| GENERAL WARDS |  | | | | | NICU/PICU/SCBU | | |  |
| ELDERLY CARE |  | | | | | MEDICAL | | |  |
| NURSING HOMES |  | | | | | GYNAECOLOGY | | |  |
| PALLATIVE |  | | | | | ODP | | |  |
| ITU |  | | | | | OCCUPATIONAL HEALTH | | |  |
| TRUAGE |  | | | | | HEALTH VISITOR | | |  |
| THEATRE |  | | | | | UROLOGY | | |  |
| PRISON |  | | | | | ONCOLOGY | | |  |
| RADIOLOGY |  | | | | | PAEDIATRICS | | |  |
| ORTHOPEDICS |  | | | | | PAEDIATRIC A&E | | |  |

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| **WORK PREFERENCE** | | | | | | | |
|  | | | | | | | |
| PART TIME |  | | | FULL TIME | | |  |
| DAYS |  | | | NIGHTS | | |  |
| WEEKDAY |  | | | WEEKENDS | | |  |
|  | | | | | | | |
| NHS | |  | NURSING HOME | |  | HOMECARE |  |
| PRIVATE HOSPITAL | |  | COMMUNITY | |  | PRISON |  |
| OTHER (PLEASE SPECIFY) | | | Enter any details for other preference of work placements. | | | | |

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| **DECLARATION OF CRIMINAL RECORD** | | | | |
| *Due to the nature of the work for which you are applying, Section 4 (2), and further Orders made by the Secretary of State under the provision of this section of Rehabilitation of Offenders Act (1974) (Exceptions) Order 1975 applies. Applicants are required to give information about convictions which for other purposes are “spent” under the provisions of the Act. Any information given will be confidential and will be considered only in relation for positions to which the order applies.* | | | | |
| DO YOU HAVE ANY CONVICTIONS, CAUTIONS OR REPRIMANDS THAT ARE NOT "PROTECTED" AS DEFINED BY REHABILITATIONS OF OFFENDERS ACT (AMENDED 2013)? | YES |  | NO |  |
| HAVE YOU EVER HAD DISCIPLINARY ACTION AGAINST YOU? IF YES PLEASE PROVIDE DETAILS. | YES |  | NO |  |
| ARE YOU AT PRESENT THE SUBJECT OF CRIMINAL CHARGES OR DISCIPLINARY ACTION? | YES |  | NO |  |
| DO YOU CONSENT TO FOUR PLUS SOLUTIONS REQUESTING A POLICE CHECK AND ANY APPROPRIATE REFERENCE ON YOUR BEHALF? | YES |  | NO |  |
| HAVE YOU BEEN POLICE CHECK IN LAST THREE YEARS? IF SO BY WHOM? (PLEASE SUPPLY A COPY) | YES |  | NO |  |
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| **DISCLOSURE & BARRING SERVICE (DBS)** | | | | |
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| HAVE YOU EVER HAD AN **ENHANCED** DBS CHECK? | YES |  | NO |  |
| DISCLOSURE NUMBER | Enter the Enhanced DBS Disclosure Number. | | | |
| IS THIS CERTIFICATE REGISTERED WITH THE **DBS UPDATE SERVICE**? | YES |  | NO |  |

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| **WORK HISTORY AND REFERENCES** | | | | | | | | | |
|  | | *Please provide us with your updated Curriculum Vittae (CV)* | | | | | |  | |
| **1ST REFERENCE SENIOR CLINICAL** | | | | | | | | | |
| NAME | | Enter name of your 1st reference. | | | | DESIGNATION | | Enter the position of your 1st reference. | |
| ORGANISATION | | Enter the name of the organisation. | | | | ADDRESS | | Enter the address of the organisation. | |
| TELEPHONE NUMBER | | Enter the best contact telephone number. | | | | EMAIL ADDRESS | | Enter the email address. | |
| START DATE EMPLOYMENT | | Select the start date of this employment. | | | | END DATE OF EMPLOYMENT | | Select the end date of this employment. | |
| **2ND REFERENCE SENIOR CLINICAL** | | | | | | | | | |
| NAME | | Enter name of your 2nd reference. | | | | DESIGNATION | | Enter the position of your 2nd reference. | |
| ORGANISATION | | Enter the name of the organisation. | | | | ADDRESS | | Enter the address of the organisation. | |
| TELEPHONE NUMBER | | Enter the best contact telephone number. | | | | EMAIL ADDRESS | | Enter the email address. | |
| START DATE EMPLOYMENT | | Select the start date of this employment. | | | | END DATE OF EMPLOYMENT | | Select the end date of this employment. | |
| **3RD REFERENCE SENIOR CLINICAL** | | | | | | | | | |
| NAME | | Enter name of your 3rd reference. | | | | DESIGNATION | | Enter the position of your 3rd reference. | |
| ORGANISATION | | Enter the name of the organisation. | | | | ADDRESS | | Enter the address of the organisation. | |
| TELEPHONE NUMBER | | Enter the best contact telephone number. | | | | EMAIL ADDRESS | | Enter the email address. | |
| START DATE EMPLOYMENT | | Select the start date of this employment. | | | | END DATE OF EMPLOYMENT | | Select the end date of this employment. | |
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| **DETAILS OF ENGAGEMENT / EMPLOYMENT** | | | | | | | | | |
| *Please confirm how you would like your earnings to be paid* | | | | | | | | | |
| PAYE |  | | | LTD COMPANY | |  | OTHER UMBRELLA | |  |
|  | | | | | Enter Ltd Company Name and Incorporation Number. | | Enter Umbrella Details including Name and any contact details you may have. | | |
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| **BANK DETAILS** | | | | | | | | | |
| PLEASE SELECT ACCOUNT TYPE | | | Select the type of bank account to be credited. | | | | | | |
| ACCOUNT HOLDER / COMPANY NAME | | | Enter the name or company name of the bank account holder. | | | | | | |
| NAME OF BANK | | | Enter the name of the Bank or Building Society. | | | | | | |
| SORT CODE | | | Enter SORT code – should be 6 numbers only. | | | | | | |
| ACCOUNT NUMBER | | | Enter bank account number – should be 8 numbers only. | | | | | | |

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| **DECLARATIONS** | | | | | |
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| **CONFIDENTIALITY** | I hereby declare that at no time will I divulge to any person, nor use for my own or other person’s benefit, any confidential information in relation to Four Plus Solutions Ltd, or any of its respective clients, or in relation to any of their employees, business affairs, transactions, or finances which I may acquire during the term of my agreement and / or engagement with Four Plus Solutions Ltd. | | | | |
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| **HEALTH AND SAFETY** | Each agency worker has a responsibility at the start of their first shift to become familiar with the Client’s general policies including without limitation, those relating to Crash Call Procedures, the Hot Spot Mechanism for alerting the security staff that an individual is in trouble, Fire Policy and the Violent Episode Policy. | | | | |
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| **HEALTH DECLARATIONS** | * All applicants must complete the supplied health questionnaire to enable us to establish your fitness for work. We would ask all OVERSEAS candidates to provide the medical statement from their GP or medical department confirming your state of health. Your details will be passed to our Occupation Health Doctors (internal or external) to establish your fitness for work. Please sign the declaration below to allow Four Plus Solutions Ltd to release your information for inspection. * I consent to Four Plus Solutions Ltd releasing my health and immunization records for review to their chosen Qualified Occupational Health Adviser. I understand that based on this review I may be required to undergo a medical examination to establish my fitness for work. I confirm that I will immediately inform Four Plus Solutions Ltd in confidence if I am HIV Positive, Hepatitis B Positive or if I have AIDS in accordance with the Department of Health guidelines. I am aware of my obligations regarding MRSA contact and the need for screening. I agree to immediately inform Four Plus Solutions Ltd should my general condition of health change. I will inform Four Plus Solutions Ltd immediately if I discover that I am pregnant. I understand that withholding information or giving false answers may lead to dismissal or termination of engagement. I also hereby consent to Four Plus Solutions Ltd obtaining further information regarding my health from my GP or Occupational Health Department. | | | | |
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| **HEPATITIS B** | I have been advised at registration with Four Plus Solutions Ltd the importance of having the Hepatitis B vaccine. I acknowledge that I have been / am being vaccinated against Hepatitis B and will continue to maintain my immunity. I accept responsibility for my decisions, and I will ensure that I take all precautions to avoid contracting the illness and avoid accepting work within environments which are hazardous. | | | | |
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| **WORKING TIME REGULATIONS (WTR)** | 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 Four Plus Solutions Ltd not less than three months’ notice at any time. In addition, I also consent to work in excess of the maximum number of hours permitted to work at night under the directive. Please note you are under no obligation to sign either declaration. | | | | |
|  | I DO CONSENT | |  | I DO NOT CONSENT |  |
|  | FULL NAME | Enter full name. | | | |
|  | DATE | Select today’s date. | | | |
|  |  |  | | | |
| **IR35 COMPLIANCE** | I understand and fully agree that I am solely responsible for ensuring all moneys received by me via an Umbrella Company is subject to the appropriate deductions of income tax and national insurance contributions at the HMRC prevailing rate. I further understand that I am solely responsible for all income tax and national insurance liabilities related to the remuneration received by me from an Umbrella Company and I take full responsibility for the liability and repayment of any identified shortfalls should they occur. | | | | |
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| **GDPR CONSENT AND DATA PROTECTION** | I agree that Four Plus Solutions Ltd retains the right to hold this registration 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.  I hereby give my consent to Four Plus Solutions Ltd to process the following information – Personal data (name, date of birth, contact details, telephone numbers, email address, postal address, experience, training, qualifications, CV, national insurance number, gender, nationality, next of kin), Sensitive personal data (disability/health condition relevant to the role, occupational health, criminal conviction).  I consent to Four Plus Solutions Ltd to process the above personal data for the following purposes:   * To provide me with work-finding services, to process or transfer my personal data to their client/s in order to provide me with work-finding services, to process my data on a computerised database in order to provide me with work-finding services, to process my data using automated decision making processes, to process my personal data with third parties including for the purposes of internal/external audits, investigations and complaints carried out on Four Plus Solutions Ltd to ensure that the company is complying with all laws and regulations. | | | | |

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| **PERSONAL DECLARATION** | * I confirm that the information given in this registration is, to the best of my knowledge, true and that an attempt to gain placement by deception is a criminal offence. * I am permitted to work in the UK. * I understand that my registration is subject to the receipt of at least two satisfactory reference and an Enhanced Disclosure from the Disclosure & Barring Service (DBS). I give my permission to Four Plus Solutions Ltd to carry out a status check using the Update Service on my DBS Certificate and may be asked to provide a written statement regarding any information revealed on my DBS Certificate. * I undertake to inform Four Plus Solutions Ltd immediately should I be convicted of an offence in the future and will reveal ALL information contained in any Enhance Disclosure or police check. * I undertake to inform Four Plus Solutions Ltd immediately, if by virtue of their introduction, I receive an offer of permanent employment following a temporary assignment. * I undertake to inform Four Plus Solutions Ltd immediately, if by virtue of their introduction, I receive an 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 Four Plus Solutions Ltd 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 contained within the Agency Workers Staff Handbook. Made available in hard copy or online as discussed.** * I give the permission for any enquiries that need to be made to confirm such matters as qualifications experience and dates of employment, and for the release by other people or oganisations of such information as may be necessary for that purpose. * I agree that my personal details including my DBS Enhanced Disclosure may be viewed by third party auditors and potential employers. * I give permission for the processing of the personal data contained in this form for employment purposes. * I have no registrations body / any investigations existing or pending. * I declare that by signing this form I am stating that I am legally entitled or allowed to work in the UK, 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 relevant permission, my employment will be terminated with immediate effect and all details passed to the relevant authorities. In addition, I confirm that that all the information provided is true and accurate and that I received and agree to the Four Plus Solutions Ltd Terms of Engagement and Agency Workers Staff Handbook. | | | |
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|  | I DO CONSENT |  | I DO NOT CONSENT |  |
|  | Enter candidate full name. | | | |
|  | Enter candidate signature. | | | |
|  | Select today’s date. | | | |
|  |  | | | |