REGISTRATION FORM

Position Applied for:

|  |
| --- |
| Type Here |

**Section 1 – Personal Details**

|  |  |
| --- | --- |
| Title | Type Here |
| Surname | Type Here |
| Forename | Type Here |
| Date of Birth | Type Here |
| Nationality | Type Here |
| National Insurance No. | Type Here |
| Address | Type Here |
|  | Type Here |
| Postcode | Type Here |
| Telephone No. | Type Here |
| Mobile No. | Type Here |
| Email Address | Type Here |

**Details of Next of Kin** (to be notified in case of emergency)

|  |  |
| --- | --- |
| Full Name | Type Here |
| Address | Type Here |
|  | Type Here |
| Post Code | Type Here |
| Telephone No. | Type Here |
| Relationship | Type Here |

**Section 2 – Summary of Qualifications**

|  |  |  |  |
| --- | --- | --- | --- |
| Schools attended from age 11 | From | To | Estimations Passed/Grades |
| Type Here | Type Here | Type Here | Type Here |
|  |  |  |  |
|  |  |  |  |
| Further Education | From | To | Estimations Passed/Grades |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Section 3 – Professional Qualifications (if applicable)**

Please state any professional qualifications/training you have:

|  |
| --- |
| Type Here |

**Section 4 – Qualified Nurses Only**

|  |  |
| --- | --- |
| Name of Training School/University | Type Here |
| Address | Type Here |
| Post Code | Type Here |
| Attended  | From: Type Here | To: Type Here |

**Professional Registration Details**

|  |  |
| --- | --- |
| Registration Body(e.g. NMC) | Type Here |
| Registration No | Type Here |
| Exp Date | Type Here |
| Are you a member of any union (e.g. RCN, Unison, etc)?  | Yes / No |
| If yes, please give details |
| Type Here |

**Section 5 – Employment Record**

Please complete if you are currently in employment or have previous work experience. Stating the most current first and covering your full employment history. Please ensure the reason for leaving section is completed in all circumstances.

(Continue on a separate sheet if necessary)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Employees Name and Address | Position held  | From | To | Reason for leaving |
| Type Here | Type Here | Type Here | Type Here | Type Here |
| Type Here | Type Here | Type Here | Type Here | Type Here |
| Type Here | Type Here | Type Here | Type Here | Type Here |
| Type Here | Type Here | Type Here | Type Here | Type Here |

**Section 6 – Mandatory Requirements**

Please provide the dates that you last undertook the following training courses and provide a copy of certificates.

|  |  |  |
| --- | --- | --- |
| **Training Course** | **Date of Last Training** | **Date Update Required** |
| Health and Safety | Type Here | Type Here |
| Information Governance | Type Here | Type Here |
| Fire Safety | Type Here | Type Here |
| Equality and Diversity | Type Here | Type Here |
| Infection Control | Type Here | Type Here |
| Food Hygiene | Type Here | Type Here |
| Basic Life Support | Type Here | Type Here |
| Moving and Handling | Type Here | Type Here |
| Safeguarding Vulnerable Adults | Type Here | Type Here |
| Dementia Care | Type Here | Type Here |
| Medication Management / Administration(For Qualified Nurses Only) | Type Here | Type Here |
| Health and Safety | Type Here | Type Here |

**Section 7 – Work Preference (please tick or cross the chosen option) ✔**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Full Time | Part Time | Weekends | Weekdays | Nights |
| Suitable date to commence | Type Here |
| Please state geographical locations in which you would like to work | Type Here |

**Section 8 – General Information**

|  |  |
| --- | --- |
| Do you hold current full driving license? Yes / No | Type Here |
| Do you have a car available? Yes / No | Type Here |
| Do you speak any other languages as well as English? Yes / No | Type Here |

**Section 9: Declaration of Health**

Please answer ‘Yes’ or ‘No’. (If yes please give details).

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you suffered or currently suffering from?** | **Yes** | **No** | **If yes, please give details (attach a separate sheet if necessary)** |
| Tuberculosis, Asthma, Bronchitis |  |  |  |
| Hepatitis/Jaundice  |  |  |  |
| German Measles, Varicella (Chicken pox) |  |  |  |
| Chest Pain, Heart Condition or High Blood Pressure |  |  |  |
| Epilepsy, Fits, Fainting Attacks, Black outs |  |  |  |
| Diabetes  |  |  |  |
| Depression, Mental Illness, Nervous breakdown or have you been referred for psychiatric assessment  |  |  |  |
| Skin allergy (Allergies) |  |  |  |
| Back/Neck pain or back/ neck injury  |  |  |  |
| Any other current or recent medical condition or treatment which might affect your attendance / performance at work |  |  |  |
| Please give details of any relevant or ongoing medication you are taking |  |  |  |

**Section 10 – Rehabilitation of Offenders Act 1974**

By virtue of the rehabilitation act 1974 (exemptions) order 1975, the provisions of section 4.2 of the rehabilitation of offenders act 1974 does not apply to any employment which is concerned with the provision of health services and which is such a kind as to enable the holder to have access to persons in receipt of such services in the course of his/her normal duties you should therefore state any convictions/offenses/cautions/ reprimands whether spent or unspent. This is information of which you are not entitled to withhold.

|  |  |
| --- | --- |
| Have you ever been convicted of a criminal offense? Yes / No | Type Here |
| Have you ever been cautioned or issued with a formal warning for any criminal offence? Yes/No*(If you have answered “yes” please attach the details including dates on a separate sheet)* | Type Here |

CRB: The criminal records bureau is the executive agency of the home office responsible for conducting checks. All nurses and care staff will be asked to supply for an enhanced disclosure with the criminal records bureau. Simple Care Solutions will offer their full support throughout this process.

**Section 11 – References**

Please give details of two references (who should not be relatives or friends)) one of whom should be your last or current employer relating a period of not less than three months employment.

|  |  |
| --- | --- |
| Full Name | Type Here |
| Address | Type Here |
| Telephone Home | Type Here |
| Mobile | Type Here |
| Email | Type Here |
| Occupation | Type Here |

|  |  |
| --- | --- |
| Full Name | Type Here |
| Address | Type Here |
| Telephone Home | Type Here |
| Mobile | Type Here |
| Email | Type Here |
| Occupation | Type Here |

**Section 12 – Passport and Work Permits**

People with automatic rights to work are citizens of the United Kingdom. European union, EEA and certain commonwealth citizens of the United Kingdom.

|  |  |
| --- | --- |
| Do you need permission to work in the UK? Yes / No | Type Here |
| Are you visiting Britain on a working holiday? Yes / No | Type Here |
| Do you require a work permit or other permission to take employment in the UK? Yes / No If yes, please provide details below: | Type Here |
|  |
| Do you have a work permit? Yes / No | Type Here |
| Expiry Date | Type Here |
| Passport / Nationality | Type Here |
| Place of Issue | Type Here |
| Date of Issue | Type Here |
| Passport Expiry Date | Type Here |

**Section 13 – Declaration**

I hereby certify that I am medically and physically fit to work within a care home and community setting. I confirm that the information on this form are correct and I understand that the employment will be considered subject to the above being correct.

|  |  |
| --- | --- |
| Signed |  |
| Printed Name | Type Here |
| Date | Type Here |