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| |  | | --- | | Attach Photograph |   **APPLICATION FORM**  **Please complete this form in black ink and complete all sections**     |  |  | | --- | --- | | **Position Applied for** |  | | **Your Surname and Initials** |  |     **Data Protection Statement**    The personal information (data) collected on this form, and on the attachments, (which includes the collection of sensitive personal data) are collected for the purposes of recruitment, personnel administration (for new employees)  and monitoring. Unless you direct otherwise (for example in a situation where you would like this Application kept on  file for future vacancies) the Application Forms (and attachments) of unsuccessful applicants will be destroyed after 6 months. It is the policy of the Agency to protect, and keep secure, all personal data collected. All personal data is processed for the purposes of recruitment, and, in the case of successful Applicants, for the satisfactory administration of their employment, and for no other purpose.      **Equality of Opportunity Statement**    The Organisation’s Equal Opportunities Policy covers all employees, or potential employees, and embraces the principle that all people shall be treated equally, regardless of their age, gender, ethnic origin, nationality, colour, religion, marital status, sexual orientation, religion or belief, disability, or offending background. |

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| **1.Personal Details** | | | | | | | | | | | | | | | |
| **Title** |  | | **Surname** | | |  | | | | | **Maiden Name** | |  | | |
| **Previous surnames (if any)** | | | | |  | | | | | | | | | | |
| **Forenames (in full)** | | | | |  | | | | | | | | | | |
| **Address** | |  | | | | | | | | | | | | | |
|  | | | | | | | | | | **Post Code** | | | |
| **Telephone** | | **Home** | | | | | | **Work** | | | | **Mobile** | | | |
|  | | | | | |  | | | |  | | | |
| **Email address** | |  | | | | | | | | | | **Nationality** | |  | |
| **May we contact you at work?** | | **Yes No Please** Ö **as appropriate** | | | | | | | | | | | | | |
| **Date of Birth** | |  | | | | | | **National Insurance Number** | | | |  | | | |
| **Next of Kin to be notified in case of emergency: Name** | | | | | | | | |  | | | | | | |
| **Address** | |  | | | | | | | | | | | | | |
|  | | | | | | | | | | **Post Code** | | | |
| **Telephone** | | **Home** | | | | | | **Work** | | | | **Mobile** | | | |
|  | | | | | |  | | | |  | | | |
| **Relationship to you** | | | |  | | | | | | | | | | | |
| **2. Formal Education and Qualifications** | | | | | | | | | | | | | | | |
| **Name of**  **School/College/University and Location** | | | | | **Dates of attendance** | | | | | **Course of**  **Study/Qualification(s) gained e.g. GCSE’s, “A” levels, NVQ, Degree etc** | | | | | **Grade** |
| **From** | | **To** | | |
| **Month/Year** | | **Month/Year** | | |

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| **3. Employment History**  **Please print details of all your employment for a period of at least the last 10 years, to include all nursing agency memberships, in reverse date order; starting with your present or last position. Please include reasons for gaps.** | | | | |
| **Name & address of**  **Employer** | **Dates of Employment** | | **Position held and brief summary of duties and responsibilities** | **Reason for leaving/Last salary or wage** |
| **From** | **To** |
|  |  |
|  | **Month/Year** | **Month/Year** |  |  |
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| **4.Training – e.g. Manual handling, CPR, infection control, first aid etc, (please provide certificates)** | | | | |
| **Details of training**  **Hospital/establishment** | **Date from Date to** | | **Courses taken** | **Attainment** |
|  |  |  |  |  |
| **5. Professional Details** | | | | |
| The service we give depends on accurate up to date information. Please keep us informed of all developments in your career. To assist us in finding suitable work for you, please tick all nursing specialities of which you have significant, post training experience.  **Please** Ö **as appropriate**   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | Ö | Yrs. exp. |  | Ö | Yrs. exp. |  | Ö | Yrs. exp | | A & E |  |  | Isolation |  |  | Phlebotomy |  |  | | Aero medical |  |  | ITU |  |  | Practice nursing |  |  | | AIDS/HIV+ |  |  | Learning disabilities |  |  | Psychiatry |  |  | | Anaesthetics |  |  | Liver Unit |  |  | Radiotherapy |  |  | | Burns and plastic |  |  | Marie Curie |  |  | Recovery |  |  | | Cardio-thoracic |  |  | Medical |  |  | Renal Dialysis |  |  | | CCU |  |  | Mental Health |  |  | SCBU |  |  | | Dental Nursing |  |  | Midwifery |  |  | Screening |  |  | | Dermatology |  |  | Nanny |  |  | Social Work |  |  | | District nursing |  |  | Neurology |  |  | STDs |  |  | | Elderly care |  |  | NNU |  |  | Surgical |  |  | | ENT |  |  | Occupational Health |  |  | Terminal care |  |  | | Family Planning |  |  | ODA |  |  | Theatre |  |  | | Genito-urinary |  |  | Oncology |  |  | Tropical disease |  |  | | Gynae |  |  | Ophthalmic |  |  | Venepuncture |  |  | | Haematology |  |  | Orthopaedic |  |  | X Ray |  |  | | ICU |  |  | Paediatrics |  |  |  |  |  | | Industry |  |  | NVQ Details |  | |  | |  |     Please give details of any certificates or qualifications you hold. (Including any in specialities listed above.) | | | | |
| **Please indicate your level of proficiency according to the scale below I no experience**   1. **previously performed but not proficient** 2. **competent to perform independently**     **Please** Ö **as appropriate**     |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Cardiovascular** |  |  |  | **Respiratory** |  |  |  | | **Skill** | **I** | **II** | **III** | **Skill** | **I** | **II** | **III** | | Administering intravenous therapy – via pump  - via giving set |  |  |  | Administering oxygen therapy |  |  |  | | Basic ECG interpretation |  |  |  | Care of patient using CPAP |  |  |  | | Care of patient post cardiac surgery |  |  |  | Care of patient with chest tubes/underwater sealed drainage |  |  |  | | Care of patient post vascular surgery eg fem/pop bypass |  |  |  | Care of patient with COAD/COPD |  |  |  | | Care of patient with congestive cardiac failure |  |  |  | Care of the ventilated patient |  |  |  | | CVP readings |  |  |  | Interpret arterial blood gas results |  |  |  | | Perform ECG |  |  |  | Perform chest physio |  |  |  | | Use of cardiac monitory equipment |  |  |  | Pulse oximetry |  |  |  | | Use of defibrillator |  |  |  | Respiratory status assessment skills |  |  |  | | Venepuncture |  |  |  | Suctioning – oropharyngeal   * nasopharyngeal * tracheostomy |  |  |  | |  |  |  |  | Tracheostomy care |  |  |  | | | | | |

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| 7. English Language Requirements |  |  |
| Candidates are required to achieve a Level 7, however, this can now be done over two sittings. Candidates can now appear for two tests within a span of six months and score a Level 7 at least once in each category across both the tests, without scoring less than 6.5 in any category.   * All applicants must also meet English language requirements, with an International English Language Test (IELTS) score of 7.0 * Any English Language Test (IELTS) taken more than 2 years ago will be in valid and candidates will have to retake this exam. | | |
| English Language Test Result | Grade | Date Taken |
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| Note: | | |

**Please indicate your level of proficiency according to the scale below**

1. **no experience**
2. **previously performed but not proficient**
3. **competent to perform independently**

# Please Ö as appropriate

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| **Neurological** |  |  |  | **Orthopaedics** |  | |  |
| **Skill** | **I** | **II** | **III** | **Skill** | **I** | **II** | **III** |
| Care of head injury patient |  |  |  | Application of POP casts |  |  |  |
| Care of patient during/ post seizure |  |  |  | Care of patient post hip replacement |  |  |  |
| Care of post craniotomy |  |  |  | Care of patient post joint reconstructions |  |  |  |
| Care of patient post neck/back surgery |  |  |  | Care of patient post total knee replacement |  |  |  |
| Care of patient post spinal cord injury |  |  |  | Care of patient using CPM |  |  |  |
| Perform neurological observations |  |  |  |  |  |  |  |
| Use of Glasgow coma scale |  |  |  |  |  |  |  |

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| **Gastrointestinal** |  |  |  | **Renal** |  | |  |
| **Skill** | **I** | **II** | **III** | **Skill** | **I** | **II** | **III** |
| Abdominal assessment eg. For bowel sounds etc |  |  |  | Care of and AV fistula |  |  |  |
| Administration of enemas |  |  |  | Care of a patient post nephrectomy |  |  |  |
| Administration of NG feeds – bolus  - via pump eg |  |  |  | Care of a patient post renal transplant |  |  |  |
| Administration of suppositories |  |  |  | Care of nephrostomy |  |  |  |
| Care of abdominal drains |  |  |  | Care of patient with renal failure – chronic  - acute |  |  |  |
| Care of colostomy |  |  |  | Insertion of urinary catheter – male   * female * short term/intermittent |  |  |  |
| Care of ileostomy |  |  |  | Manage peritoneal dialysis |  |  |  |
| Care of patient post gastrointestinal surgery |  |  |  | Manage venous dialysis |  |  |  |
| Care of patient with hepatitis |  |  |  | Perform bladder irrigation – continuous  - intermittent |  |  |  |
| Care of patient with inflammatory bowel disease |  |  |  | Perform urinalysis |  |  |  |
| Care of percutaneous endoscopic gastrostomy (PEG) tube |  |  |  |  |  |  |  |
| Care of T-tube |  |  |  |  |  |  |  |
| Check placement of NGT |  |  |  |  |  |  |  |
| Flexiflo systems |  |  |  |  |  |  |  |
| Insertion of nasogastric tube (NGT) |  |  |  |  |  |  |  |

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| **Endocrine/Metabolism** |  |  |  | **Infection control** |  | |  |
| **Skill** | **I** | **II** | **III** | **Skill** | **I** | **II** | **III** |
| Blood sugar level testing |  |  |  | Assessment and care of pressure sores/ulcers |  |  |  |
| Care of total parental nutrition infusion/lines |  |  |  | Burn care |  |  |  |
| Care of patient post a drug overdose |  |  |  | Care of surgical drains |  |  |  |
| Care of patient with diabetes insipidus/ disorders of the pituitary gland |  |  |  | Care of the isolated patient |  |  |  |
| Care of patient with thyroid disorders |  |  |  | Knowledge of universal precautions |  |  |  |
| Diabetic education |  |  |  | Wound care |  |  |  |
| Disorders of the adrenal gland |  |  |  | Wound packing/irrigation |  |  |  |
| Insulin administration |  |  |  |  |  |  |  |
| Management of a sliding scale of insulin |  |  |  |  |  |  |  |
| Management of insulin dependent diabetes mellitus |  |  |  |  |  |  |  |
| Management of IV insulin infusion |  |  |  |  |  |  |  |
| Management of non-insulin dependent diabetes mellitus |  |  |  |  |  |  |  |

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| **6. General information** | |
| **Do you hold a valid and current British Driver’s Licence? Yes, No Please** Ö **as appropriate If Yes, what type? (E.g. Provisional, Full, LGV, PCV)**  **Do you have any endorsements? Yes, No Please** Ö **as appropriate If Yes, please give details** | |
| **Please state which languages you speak, including an indication of fluency** |  |
| **How did you hear about this agency?** |  |
| **Are you a member of a Union or Professional Organisation offering Indemnity Insurance?**  **Yes No Please** Ö **as appropriate** | |
| **Body Name** | **Amount of Cover** |
| **Policy Number** | **Expiry Date** |

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| **7. Preference regarding work** | |
| **Please specify which types of work you would prefer. You should tick all appropriate boxes. The service we give depends on accurate, up to date information. Please keep us informed of all developments, in your career and work preferences.**    **Positions part time full time**  **Type of work NHS private hospitals nursing home industry**  **Clients in their own home Other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Live in Days Nights Visits**  **Do you have any other work commitments? Yes No** | |
| **Which areas of work do you wish to exclude?** |  |
| **When will you be available to start work?** |  |

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| **8. Immunisations-proof of immunisations must be provided** | | | | | | | | |
| **Rubella** | **Yes No** | | **Date** | |  |  | | |
| **Skin Test for TB** | **Yes No** | | **Date** | |  |  | | |
| **BCG** | **Yes No** | | **Date** | |  |  | | |
| **Tetanus** | **Yes No** | | **Date** | |  |  | | |
| **Varicella**  **(Chickenpox/Vz.Abs)** | **Yes No** | | **Date** | |  |  | | |
| **Poliomyelitis** | **Yes No** | | **Date** | |  |  | | |
| **Diptheria** | **Yes No** | | **Date** | |  |  | | |
| **Hepatitis B** | **Date of last injection** | | **Booster 1st** | | **2nd** | **3rd** | | |
| **Covid Vaccination** | **1st Dose**  **2nd Dose** | | | | | | | |
| **9. References**  References are normally taken up for candidates selected for interview. Give details of the names/addresses of two work-related Referees. One of the Referees should be your current employer, or if presently unemployed or self-employed, your last employer | | | | | | | |
| **Name, Address and Post Code** | | | | **Name, Address and Post Code** | | | |
|  | | | |  | | | |
| **Telephone Number** | |  | | **Telephone Number** | | |  |
| **Position** | |  | | **Position** | | |  |
| **Relationship to you** | |  | | **Relationship to you** | | |  |
| **May we contact the above person now?**    **Yes No Please** Ö **as appropriate** | | | | **May we contact the above person now?**    **Yes No Please** Ö **as appropriate** | | | |

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| **10. GDPR/Confidentiality declaration** |
| Registration implies acceptance of our code of confidentiality. In the course of your duties, you may have access to confidential information about your clients. On no account must information relating to identifiable client be divulged to anyone other than the manager of the agency. You should not disclose ANY information to your family, friends or neighbours. If you are worried by any information you have obtained and consider that you should talk about it to someone else MAKE AN APPOINTMENT TO SPEAK IN PRIVATE TO YOUR MANAGER.  Failure to observe these rules will be regarded as serious misconduct which could result in removal from the agency register. I have read and I understand the above and I agree to abide by the contents therein. I give Gain Healthcare Consent to retain my information for seven years.    Signed Date |

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| **11. Rehabilitation of Offenders Act** |
| As a general rule, no-one needs answer questions about spent convictions. However, this general rule does not apply to specified professions, employments and occupations. By virtue of the Rehabilitation of Offenders Act 1974 (Exceptions) (Amendment) Orders, the exemption rule does not apply to:     1. any employment or other work which is concerned with the provision of health services and which is of such a kind as to enable the holder of that employment or the person engaged in that work to have access to persons in receipt of such services in the course of his normal duties, or 2. any employment or other work which is concerned with the provision of care services to vulnerable adults and which is of such a kind as to enable the holder of that employment or the person engaged in that work to have access to vulnerable adults in receipt of such services in the course of his normal duties     One or both of the above apply to work with the Agency, and covers all occupations.    You are therefore requested to provide details of all convictions, including those which would otherwise be considered as “spent”. *All employment applications will be considered carefully, and the disclosure of a conviction does not imply that this employment application will be rejected.*    **Records will be checked via the Disclosure Barring Service procedures**  **I have no convictions I have convictions (see Note below)**  **Please** Ö **as appropriate**    **Note**  (To protect the confidentiality of this information, please detail convictions on a separate sheet of paper. Place it in a sealed envelope with your name clearly visible, and headed “Private and Confidential – Criminal Convictions” and  attach this to your completed Application Form) |
| **Criminal Records – Disclosure Certificate** |
| The Disclosure Barring Service have issued a Code of Practice regarding Disclosure Information, a copy of which is available upon request. A Disclosure Certificate (standard or enhanced) will be requested from the DBS which will detail all convictions, including those which would otherwise be “spent”, as well as details of cautions, reprimands or final warnings. You will be advised of the type of certificate being requested, and asked to give your approval to this application. The Disclosure Certificate will only be requested in the event that you are successful in your application for employment. |
| **Asylum and Immigration Act 1996** |
| Under Section 8 of the Asylum and Immigration Act 1996 it is a criminal offence to employ a person aged 16 or over who is subject to immigration control unless:     * That person has current and valid permission to be in the United Kingdom and that permission does not prevent him or her from taking the job in question; or      * The person comes into a category specified by the Home Secretary where such employment is allowed     Any employment offered will be subject to the successful applicant producing appropriate evidence that the Asylum and Immigration Act is not being contravened.    **Are you eligible to work in the UK? Yes, No Please** Ö **as appropriate** |
| |  |  |  | | --- | --- | --- | |  | **Personal Declaration** |  |   **I declare that to the best of my knowledge the above information, and that submitted in any accompanying documents, is correct, and**     * I give 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 organisations of such information as may be necessary for that purpose.   * I give permission for the processing of the personal data contained in this form for employment purposes * I understand that any false or misleading information could result in my dismissal.       **Signed**  **Date** |

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| **48 Hour Working Week Agreement (Employee)** |

DEFINITIONS

In this Agreement the following definitions apply: -

“Employer” means *Gain Healthcare Ltd*

“Employee” means *Contract Worker*

“Working Week” means an average of 48 hours each week calculated over a 17 week reference period.

References to the singular include the plural and references to the masculine include the feminine and vice versa.

The headings contained in this Agreement are for convenience only and do not affect their interpretation.

RESTRICTION

The Working Time Regulations 1998 provide that the Employee shall not work in excess of the Working Week unless he agrees in writing that this limit should not apply.

CONSENT

The Employee hereby agrees that the Working Week limit shall not apply.

WITHDRAWAL OF CONSENT

The Employee may end this Agreement by giving *14day* notice in writing.

For the avoidance of doubt, any notice bringing this Agreement to an end shall not be construed as notice of termination by the Employee.

Upon the expiry of the notice period set out in clause 4.1 the Working Week limit shall apply with immediate effect.

THE LAW

These Terms are governed by the law of England & Wales and are subject to the exclusive jurisdiction of the Courts of England & Wales

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signed by the Employee*

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Bank Details** |

TITLE: MR/MRS/MISS/MS/\_\_\_\_\_\_\_\_\_\_ GENDER (M/F) \_\_\_\_\_\_\_\_\_\_\_\_\_\_MARITAL STATUS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FIRST NAMES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_LAST NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_\_\_\_NATIONAL INSURANCE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TOWN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POST CODE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TEL NO.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BANK DETAILS:**

NAME OF BANK \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BRANCH NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SORT CODE (6 DIGITS) \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_. ACCOUNT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACCOUNT NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BUILDING SOCIETY REFERENCE/ROLL NO.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **12. Equal Opportunities Monitoring Form**  **Gain Healthcare Ltd operates a policy of Equal Opportunities: therefore, we need to be able to check that decision are not influences by unfair or unlawful. discrimination. To help use to do this we would be grateful if you could complete this short questionnaire. Your answers will be treated with the utmost confidence and will be used only for statistical purposes.** |

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| **What is your ethnic group?**  **Choose ONE section from A to E, and then circle the appropriate box to indicate your cultural background.**     1. **White**     British    Irish  Any other White background, please write in here.     1. **Mixed**     White and Black Caribbean    White and Black African    White and Asian    Any other Mixed background, please write in here.     1. **Asian or Asian British**     Indian    Pakistani    Bangladeshi    Any other Asian background, please write in here.     1. **Black or Black British**     Caribbean    African    Any other Black background, please write in here.     1. **Chinese of another ethnic group**     Chinese    Any other, please write here.  **SEX Female Male**    **DISABILITY**  **Applicants with disabilities will be invited for interview if the essential job criteria are met. Do you consider yourself to be a person with a disability as described by the disability discrimination act 1995? i.e. do you consider yourself to be someone who has a physical or mental impairment which has a substantial and long-term adverse effect on your ability to carry out normal day to day activities**    **Yes No** |

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|  | **OFFICE USE ONLY** |  |
|  |  | **Initials** |
| **Date Application received** |  |  |
| **Date Application acknowledged** |  |  |
| **Initial Decision** |  |  |
| **Date Applicant informed** |  |  |
| **Date(s) of Interview** |  |  |
| **Decision** |  |  |

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| **Recruitment Checklist:** | | | |
|  | **Initial** | **Date \ Comment** |
| Registration form complete all sections signed |  | |
| Full employment history gaps explained, reasons for leaving |  |  |
| Record of Interview |  |  |
| Proof of ID - Passport, Birth Certificate, Marriage Certificate |  |  |
| Proof of address (utility bill, bank statements) |  |  |
| Proof of NI (, P45, tax letter) |  |  |
| Proof of right to work and valid until |  |  |
| Evidence of qualifications / training (originals) |  |  |
| Evidence of satisfactory written & verbal communication skills |  |  |
| Photo x2 |  |  |
| Written refs x2 (From last 2 previous employers) |  |  |
| Enhanced DBS and Number (proof of ISA first check if used) |  |  |
| DBS Issue Date |  |  |
| Health assessment / vaccinations completed |  |  |
| Handbook issued; declarations signed |  |  |
| Proof of ID badge issued (photocopy both sides) |  |  |
| Job Description and rates issued |  |  |
| DBS money paid |  |  |
| Key Induction and date |  |  |
| Driver? |  |  |
| Student? |  |  |
| Regulatory Body Pin Number |  |  |
| Web check |  | |
| Revalidation |  |  |
|  |  |  |
| **Training** |  |  |
| Moving & Manual Handling |  |  |
| Fire |  |  |
| Health & Safety |  |  |
| Infection Control |  |  |
| COSHH |  |  |
| RIDDOR |  |  |
| Medication |  |  |
| First Aid Awareness |  |  |
| Basic life support |  |  |
| Nutrition |  |  |
| Food Hygiene |  |  |
| Mental Capacity Act |  |  |
| Lone Worker /Management of aggression awareness |  |  |
| Breakaway Techniques |  |  |
| Mental Health Awareness |  |  |
| Equality & Diversity |  |  |
| Information Governance |  |  |
| Confidentiality/Data protection |  |  |
| Safeguarding (adults and children Level 3) |  |  |
| Immediate Life Support (ILS) (qualified staff must be ILS trained) |  |  |
|  |  |  |
| **All staff supplied as specialists must have relevant training & competence training** |  |  |
|  |  |  |
| **Verification by Subcontractor** |  |  |
| I hereby confirm that I have seen the original document |  |  |
| Name Person Completing the Form |  |  |
| Position | |  |
| Sign |  |  |
| Date | |  |
| **For Completion by Gain Healthcare Ltd** | |  |
| Compliances verified by: |  |  |
| Position Sign |  |  |
| Date |  |  |
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