



Stone House
Care & Medical Ltd

APPLICATION FORM

Stone House Care and Recruitment
Avix Business Centre
42-46 Hagley Road
Birmingham
West Midlands
B16 8PE

Tel: 01217400214
email: recruitment@stonehousecare.com
www.stonehousecare.com

Registered in England
Registered No. 10566936

Registered Office:
Avix Business Centre
42-46 Hagley Road
Birmingham
West Midlands
B16 8PE



To help us with your application please answer the questions within this form in black ink.
 If you have any questions, please contact our office. Our consultants will be happy to assist you with your application.

You will be expected to bring the following for us to help you with your application form:

All Applicants

Proof of identity - EU passport/ Non-EU passport or full British birth certificate	
Work Permit or Visa (if required)	
Documentation of your National Insurance Number - NI card, P60, P45, letter from HMRC or DWP	
Two forms of proof of current address are required for the DBS application - utility bill, bank statement	
Completed Enhanced disclosure application (DBS) form	
Letter from your college/university (if you are an international student)	
Vaccination report from your GP or Occupational Health Department - Hepatitis, MMR, TB, Varicella (chicken pox)	
Details of Manual Handling and Basic Life Support Training as well as original certificates in relevant field i.e. nursing, care or support work	

Qualified Nurses must also include the following

NMC Statement of entry, (not GNC or ENB certificate).	
PIN card, (Name and number must correspond with details on the card)	
Post qualification certificates relevant to practice	
Proof of professional indemnity insurance, i.e. RCN/Unison	

PLEASE ENSURE YOU BRING ALL REQUESTED DOCUMENTATION WITH YOU WHEN YOU COME TO REGISTER. OUR CONSULTANTS WILL NOT BE ABLE TO REGISTER YOU WITHOUT THEM.

1.0 Your Personal Details:

Surname:	Forename:
Previous names: incl. maiden name	Title:
Contact Details:	
Current address:	Home Tel:
County:	Mobile:
Post code:	Other:
Date of Birth:	Email:
Emergency Contact:	For Payroll Purposes ONLY
Full Name:	Nationality:
Relationship:	Passport No:
Tel number 1:	Date of Issue:
Tel number 2:	Place of issue:
Next of Kin (if different from above):	Date of expiry:
Full Name:	Work Permit/Visa: e.g. tier 2 or N/A
Relationship:	Date of expiry:
Tel number 1:	Position applied for:
Tel number 2:	N I number:

Rehabilitation of Offenders Act

By virtue of the Rehabilitation of Offenders Act 1974 (Exemptions) Amendments Order 1986, the provision 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 of such a kind as to enable the holder to have access to persons in receipt of such services during his/her normal duties. Your answer to the following questions should include any spent convictions. This may or may not affect your application. All Nurses and Care Staff will be asked to apply for an Enhanced Disclosure with the Disclosure and Barring Service as part of the recruitment and selection process.

<p>Have you ever been convicted of a criminal offence?</p> <p>If 'Yes', please give details.</p> <p>Date of conviction:</p> <p>Nature of conviction: Please continue on 'Section 7.0 Your Notes' or on a separate sheet if required</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Are you currently the subject of criminal proceedings? (e.g. charges or summons that are not yet being dealt with)</p> <p>If 'Yes', please give details.</p> <p>Date of charges:</p> <p>Nature of charges: Please continue on 'Section 7.0 Your Notes' or on a separate sheet if required</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Have you ever been dismissed from a nursing post?</p> <p>If 'Yes', please give details:</p> <p>Date of dismissal:</p> <p>Nature of dismissal: Please continue on 'Section 7.0 Your Notes' or on a separate sheet if required</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Are you currently suspended, on notice of dismissal from employment or under investigation from any employer?</p> <p>If 'Yes', please give details: Please continue on 'Section 7.0 Your Notes' or on a separate sheet if required</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Are you currently on maternity leave?</p> <p>Do you belong to a union or professional body?</p> <p>Do you have professional indemnity cover?</p> <p>Do you belong to any other agencies or staff banks?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No



2.0 Your Work Preferences

How many hours would you like to work with us?

- Full time
- Part time
- Days
- Nights
- Weekdays
- Weekends
- Any of the above

Which areas would you like to work in?

- Medical wards
- Surgical wards
- Acute
- Psychiatric
- Paediatrics
- Clients in their homes
- Nursing Homes
- Learning Disabilities

Are you a car owner?

Yes / No

Do you have a full British Driving Licence? Yes / No

If not, state details: _____

Motor Insurance No: _____ Insurance Provider: _____ Expiry: _____

You have the option to opt out of the 48 hour working week limitation as laid out in the Working Time Regulations 1998. Please indicate one of the following:

I wish to opt out I do not wish to opt out

If your circumstances change, please inform the office in writing allowing a 14 day notice period.

3.0 Your Qualifications

Please continue on 'Section 7.0 Your Notes' or on a separate sheet if required

Have you completed any of the following courses? (Please tick):

Control & Restraint Yes/ No Dates: _____ Managing Challenging Behaviour Yes/ No Dates: _____

Manual Handling Yes/ No Dates: _____ First Aid Yes/ No Dates: _____

NVQ Yes/ No Dates: _____ Food Hygiene Yes/ No Dates: _____

CPR Yes/ No Dates: _____ Health & Safety Yes/ No Dates: _____

3.1 Other Courses (please specify):

Course	Certified	Dates
_____	Yes <input type="checkbox"/>	No <input type="checkbox"/> _____
_____	Yes <input type="checkbox"/>	No <input type="checkbox"/> _____



CARE ASSISTANTS

Please tick the areas you are competent and confident to work in

- ... Catheter Care
- ... Observations BP
- ... Urinalysis
- ... Fluid Charts
- ... Observations TPR
- ... Use of Hoists

3.2 To Be Completed by Registered Nurses Only

We need to know your qualifications. These are to include details of NMC registration, Post registration qualifications and any other qualifications that you think are relevant.

NMC PIN number: _____ Part of register: _____ Expiry: _____

Name of training Hospital or University	Date	Qualifications

3.3 Competency & Accountability

Please tick the areas you are competent and confident to work in

- | | | | |
|----------------------------------|---------------------------------|-------------------------|-----------------------|
| ... A & E | ... General | ... Mental Health | ... Radiology |
| ... Anaesthetic Trained | ... Dental | ... Midwifery | ... Recovery |
| ... Autism | ... Gynaecology | ... Neonatal | ... Renal |
| ... Cardiac | ... Haematology | ... Neurology | ... Residential Homes |
| ... Cardiothoracic | ... HDU | ... Nursing Homes | ... Respite Care |
| ... Care of the Elderly | ... Health Visitor | ... Occupational Health | ... SCBU |
| ... Challenging Behaviour | ... Home Care | ... ODP | ... School Nurse |
| ... Chemotherapy | ... Hospices | ... Oncology | ... Senior Care |
| ... Clinics | ... Hospitals | ... Ophthalmology | ... Social Care |
| ... CSSD | ... ITU | ... Orthopaedics | ... Social Worker |
| ... Community | ... ITU Psychiatric | ... Palliative Care | ... Support Worker |
| ... District Nursing | ... In Charge Wards | ... Practice Nurse | ... Surgical |
| ... Day care centres/hospitals | ... In Charge Nursing homes | ... Plastic Surgery | ... Terminal Care |
| ... Diabetic Care | ... In Charge Residential homes | ... Paediatrics | ... Training |
| ... EMI | ... Learning Disability | ... PICU | ... Theatre |
| ... Eating disorder | ... Medical | ... Prisons | ... Urology |
| ... Other (please specify) | | | |

THEATRE STAFF

Please tick Courses and Certificates held

- | | | |
|-------------------------|---------|---------------------|
| ... Anaesthetic Trained | ... ODO | ... Any other |
| ... ODA | ... ODP | |

SCRUB NURSES

- | | | | |
|--------------------------------|-----------------|---------------------|--------------|
| ... Cardiothoracic | ... ENT | ... Ophthalmic | ... TOP |
| ... Dental | ... General | ... Orthopaedic | ... Urology |
| ... Day surgery/scopes
etc. | ... Gynaecology | ... Plastic Surgery | ... Vascular |
| ... Endocrinology | ... Neurology | ... Recovery | |

EXPERIENCED IN: -

- | | | | |
|--------------------------|-----------------------------------|----------------------------------|--------------------------------------|
| ... Anaesthetics | ... Insertion of Laryngeal airway | ... Acute Behavioural Problems | ... PCA's & Calibration |
| ... CSSD | ... IV Cannulation | ... Anaphylactic shock | ... Running in theatre |
| ... A&E Minor Injuries | ... Ability to Plaster | ... Baby Immunisation | ... Baxter pumps |
| ... Blood obs & charting | ... Boots Monitoring Drug System | ... Care Plans/Assessment | ... Cassette Drug System |
| ... Catheterisation M/F | ... Control & Restraint | ... CVP Readings | ... Dental |
| ... Dinomaps | ... DrugRounds/Medication | ... Eating Disorders | ... ECT Treatment |
| ... Emis Computer System | ... Escort Duty (Blue light) | ... Flowtrons | ... Forensic Medicine |
| ... Gemini Pumps | ... Graseby's Pumps | ... Ileostomy Care | ... Nara Gastric feeding |
| ... Oncology Drugs | ... Out Patients Clinic | ... Passing Naso-Gastric Tubes | ... PCA inc Settings/Checks |
| ... Peg feeds | ... Pressure air care | ... Recording & Charting of BM's | ... Redivac Care |
| ... Removal of CVP Line | ... Resuscitation A&E | ... Sliding scale/Reporting | ... Smear Tests |
| ... Stoma Care | ... Suture & Clip Removal | ... Syringe Drivers | ... Tracheotomy Care |
| ... Thyroidectomy Care | ... Use of most Pumps on market | ... Ventilated Patients | ... Advanced Life Support |
| | | | ... Paediatric Advanced Life Support |

e.g. Urdu Basic or French Fluent

3.4 Languages Spoken

Please list all other languages spoken and level of ability

4.0 Your Employment History

Please continue on 'Section 7.0 Your Notes' or on a separate sheet if required

Please provide in date order details of your full employment history during the last 5 years starting with your present or latest position. Please note that to work within specialist clinical areas you will need to demonstrate that you have within the last two years, gained a minimum of 1 years' experience in your specialty. For this you must be able to provide the details of at least one professional reference within 'Section 5.0 Your References' Employers will not be approached without your permission. Please account for any intervals of non-employment and include temporary jobs and full time service.

Name & full address of Employer:	Dates:	Type of ward/dept.:	Salary:
	From:	No of beds /employees:	
	To:		
	Position Held:		Reason for leaving:

Duties/Responsibilities – Please give FULL DETAILS. Continue on Your notes if necessary.

Name & full address of Employer:	Dates:	Type of ward/dept.:	Salary:
	From:	No of beds /employees:	
	To:		
	Position Held:		Reason for leaving:

Duties/Responsibilities – Please give FULL DETAILS. Continue on Your notes if necessary.

Name & full address of Employer:	Dates:	Type of ward/dept.:	Salary:
	From:	No of beds /employees:	
	To:		
	Position Held:		Reason for leaving:

Duties/Responsibilities – Please give FULL DETAILS. Continue on Your notes if necessary.

Name & full address of Employer:	Dates:	Type of ward/dept.:	Salary:
	From:	No of beds:	
	To:		

Continued next page



	Position Held:	Reason for leaving:
--	-----------------------	----------------------------

Duties/Responsibilities – Please give FULL DETAILS. Continue on Your notes if necessary.

5.0 Your References

Please give the details of at least two referees. Additional referees can be provided in 'Section 7.0 Your Notes' or on a separate sheet if required

Present or most recent employer	Clinical referee
Full Name:	Full Name:
Occupation:	Occupation:
Address:	Address:
Tel Number:	Tel Number
Fax Number:	Fax Number:
Email:	Email:

Can we fax or email your referees to speed up the registration process? Yes No

Can we approach your referees before the interview? Yes No

6.0 Health Questionnaire

Please answer the questions below by placing a tick in the appropriate column. If your answer is yes, please give details in the space provided or continue on a separate sheet, if necessary.

	Yes	No	Details
Do you consider yourself to be in good health?			
Have you had any health issues identified during an assessment in any Occupational Health Department?			
If Yes, were you passed fit without any medical restrictions imposed on your conditions of work?			
Have you ever been retired on medical grounds or had to give up work due to ill health or injury?			
Do you consider yourself to be disabled? (The Disability Discrimination Act 1995 defines disability as: a physical or mental impairment which has a substantial and long term adverse effect on the ability to carry out normal day to day activities.)			
Have you had more than 2 weeks sick leave continuously over the past two years? (Please state reason for absence and duration of absence)			
Are you currently suffering from medical or surgical condition for which you are receiving treatment and/or awaiting a medical/surgical appointment? (Treatment includes physiotherapy, psychotherapy counselling, etc. If on prescribed medication, please give details.			
Over the last 5 years have you had any medical/surgical conditions (excluding maternity leave) which have required treatment for longer than 1 month?			
Do you currently have a medical condition for which you have not sought the help of a health professional?			
Have you ever suffered from mental health illness, anxiety, depression or other psychiatric disorder, such as nervous breakdown?			

Have you ever had a drug or alcohol problem?			
Do you have any speech, hearing or visual difficulties?			
Have you been screened for MRSA within the last 6 months?			
Do you intend to work night duties on a regular basis?			
Do you smoke? If yes please give daily amount.			
How many unit of alcohol do you drink per week? One unit = half pint beer, or 1 glass wine or 1 shot of spirit			
Are you pregnant? This question is asked to ensure only that any health needs of pregnancy are addressed, and to avoid any hazard or risk to a developing baby.			
If you have ever suffered from the following ailments/illnesses please give details of the dates, duration and outcomes in the space provided;			
	Yes	No	Details with dates
Asthma, bronchitis or chest complaints			
Chest pain, heart condition or raised blood pressure			
Blackouts, epilepsy, fits or attacks of giddiness			
Rheumatism or arthritis			
Back or neck problem			
Typhoid, paratyphoid or dysentery			
Digestive or bowel disorder			
Diabetes, thyroid or other gland problems			
Bladder or kidney problems			
Dermatitis or other skin problems.(such as psoriasis)			
Varicose veins or DVT			
Please use this space to provide any medical information about you, which you think could affect your ability to work within the health and social services environment, and for which you may require support:			

6.2 Record Of Immunity

Have you been immunised against the following? If Yes, please give the date in the space in the space provided. Please answer the questions below by placing a tick in the appropriate column.

	Yes	No	Date
Triple vaccine (Diphtheria, Whooping Cough, Tetanus)			
Tetanus			
Polio			
Rubella (German Measles)			
Varicella (Chickenpox)			
Tuberculosis			
BCG (TB Vaccination)			
Have you ever been treated for TB?			
Have you had a chest X-ray in the last 2 years?			Result:
Hepatitis A			Result:
Hepatitis B			Result:

(please provide evidence of the blood test result demonstrating Hep B titre levels):

Date 1: Date 2: Date 3:

If you have answered "No" to Hepatitis B, are you in the process of undertaking a course of immunization?

If accepted to work within the health care industry, you are required to ensure that any changes to the information given in this questionnaire or changes to your medical condition are declared.

6.4 Notice:

All applicants are reminded that it is unethical for Health Care Workers who know or believe themselves to be infected with any blood borne viruses (HIV, Hepatitis B or C) or other communicable diseases (e.g. Tuberculosis) to put patients at risk by failing to seek appropriate counselling or by failing to disclose it when notified. Such behaviour may affect your ability to practise within the healthcare industry.

6.5 Health Declaration

I certify that the answers to the questions are correct and that the information provided is true, accurate and complete.

I understand that I may be required to undergo a medical examination if necessary.

I understand that no medical details will be disclosed without my permission to any individual other than those necessary and authorised within either the Regional Health Authority or Stone House Care and Recruitment.

I understand that failure to disclose information or the giving of false information may prohibit an offer of temporary staffing assignments.

Print Name

Signature

Date



INFORMATION CHECKLIST- FOR OFFICIAL USE ONLY

NMC Statement of Entry Document Seen Photocopy

Verbal Check – Date Written Check – Date Signature

PIN Card	<input type="checkbox"/> Document Seen	<input type="checkbox"/> Photocopy
National Insurance Card	<input type="checkbox"/> Document Seen	<input type="checkbox"/> Photocopy
Visa/ Work Permit	<input type="checkbox"/> Document Seen	<input type="checkbox"/> Photocopy
Passport	<input type="checkbox"/> Document Seen	<input type="checkbox"/> Photocopy
Manuel Handling	<input type="checkbox"/> Document Seen	<input type="checkbox"/> Photocopy
Other Certificates	<input type="checkbox"/> Document Seen	<input type="checkbox"/> Photocopy
Hepatitis B	<input type="checkbox"/> Document Seen	<input type="checkbox"/> Photocopy

Titre Levels

Reference 1	Date sent	Received	<input type="checkbox"/> Accept	<input type="checkbox"/> Reject
Reference 2	Date sent	Received	<input type="checkbox"/> Accept	<input type="checkbox"/> Reject
Reference 3	Date sent	Received	<input type="checkbox"/> Accept	<input type="checkbox"/> Reject

CRB Disclosure Application: Date sent to Central Support Disclosure Number

Proof of Identity – Originals checked, tick box and attach photocopies, signed “originals seen”

<input type="checkbox"/> Passport	<input type="checkbox"/> Driving License (photo card type)	<input type="checkbox"/> Recent Utility Bill
<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Marriage Certificate	<input type="checkbox"/> Paper Driving License

P45 / 46

Completed Bank Details Form Completed

Night Assessment offered Accepted Declined

Written & Verbal Knowledge of English Unsatisfactory Satisfactory Good Excellent

Terms and Conditions Signed Photocopy

ID Badge Given Completed Expiry Date

Declaration of Health From GP Yes No Seen

Opt out agreement

Annual update required Date

Starter Form Completed – Date sent to Payroll Consultants Signature

Member Accepted Rejected Reasons

9.0 Equal Opportunities Monitoring Form

Stone House Care and Recruitment wants to meet the aims and commitments set out in its equality policy. This includes not discriminating under the Equality Act 2010, and building an accurate picture of the make-up of the workforce in encouraging equality and diversity.

The organisation needs your help and co-operation to enable it to do this, but filling in this form is voluntary.

The information you provide will stay confidential, and be stored securely and limited to only some staff in the organisation's Human Resources section.

Gender

Male Female Prefer not to say

Are you married or in a civil partnership?

Yes No Prefer not to say

Age

16-24 25-29 30-34 35-39 40-44
45-49 50-54 55-59 60-64 65+ Prefer not to say

What is your ethnicity?

Ethnic origin is not about nationality, place of birth or citizenship. It is about the group to which you perceive you belong. Please tick the appropriate box

White

English Welsh Scottish Northern Irish Irish

British Gypsy or Irish Traveller Prefer not to say

Any other white background, please write: _____

Mixed/multiple ethnic groups

White and Black Caribbean White and Black African White and Asian Prefer not to say Any other mixed background, please write in: _____

Asian/Asian British

Indian Pakistani Bangladeshi Chinese Prefer not to say

Any other Asian background, please write : _____

Black/ African/ Caribbean/ Black British

African Caribbean Prefer not to say

Any other Black/African/Caribbean background, please write : _____

Other ethnic group

Arab Prefer not to say Any other ethnic group, please write in: _____



Under the Disability Discrimination Act 1995, a person has a disability if he/she has a physical or mental impairment which has a substantial and long-term adverse effect on his/her ability to carry out normal day-to-day activities.

Do you consider that you have a disability or health condition?

No Yes Prefer not to say

If Yes, please state nature of disability, and how, if at all, it affects your performance at work.

The information in this form is for monitoring purposes only. If you believe you need a 'reasonable adjustment', then please discuss this with your manager, or the manager running the recruitment process if you are a job applicant.

What is your sexual orientation?

Heterosexual Gay woman/lesbian Gay man Bisexual

Prefer not to say If other, please write: _____

What is your religion or belief?

No religion or belief Buddhist Christian Hindu Jewish

Muslim Sikh Prefer not to say If other religion or belief, please write: _____

What is your current working pattern?

Full-time Part-time Prefer not to say

Signature:

Date.....

Any information held on this form will be subject to the Data Protection Act 1984 and 1998

For official use only:

--



Stone House
Care & Medical Ltd