



GENERAL DETAILS

TITLE: _____
 SURNAME: _____
 FORENAME(S): _____
 MARITAL STATUS: _____
 DATE OF BIRTH: _____
 GENDER: _____
 ADDRESS 1: _____
 ADDRESS 2: _____
 CITY: _____
 COUNTY: _____
 POST CODE: _____
 COUNTRY: _____
 TEL1: _____
 TEL2: _____
 OTHER No: _____
 FAX: _____
 MOBILE: _____
 E-MAIL1: _____
 E-MAIL2: _____

NEXT OF KIN DETAILS

TITLE: _____
 SURNAME: _____
 FORENAME(S): _____
 RELATIONSHIP: _____
 ADDRESS1: _____
 ADDRESS2: _____
 CITY: _____
 COUNTY: _____
 POST CODE: _____
 TEL1: _____
 TEL2: _____
 MOBILE: _____
 FAX: _____
 E-MAIL1: _____
 E-MAIL2: _____
 GP Name: _____
 GP Address: _____
 GP Telephone: _____

TYPE OF ENGAGEMENT WITH CES LOCUMS

Please tick as appropriate and provide information accordingly:

<u>TYPE</u>	<u>YES</u>	<u>NO</u>	Limited Companies, Self employed and Sole Traders are solely responsible for paying their Tax and National Insurance liabilities to the Inland Revenue. CES Locums will be handling the Income Tax and Employee's National Insurance Contribution for PAYE workers.
P.A.Y.E.			
Limited Company/Umbrella Company			
Self Employed			
Sole Trader			

PLEASE PROVIDE THE FOLLOWING DETAILS

National Insurance Number:	
Name on your Bank Account:	
Account Number:	
Sort Code:	

HOW / WHERE DID YOU HEAR ABOUT US

PRINTED ADVERT _____ ONLINE REGISTRATION _____
 WEB ADVERT _____ AGENT _____
 WORD OF MOUTH _____ OTHERS _____

IMMIGRATION STATUS / RIGHT TO WORK IN THE UK

Nationality: _____ Type of the current visa: _____
 Proof provided: _____ Valid from _____ To _____



DECLARATIONS

WTR:

Statement on Working Regulations (WTR)

The Working Time Regulations 1998 require Clinical Employment Services Limited / CES Locums to limit your average weekly working time to 48 hours unless you agree in writing that those limits shall not apply to you. In those circumstances you should complete the declaration set out below.

I agree that I do not want the Working Time Regulations to apply to me

Should I wish to terminate this agreement about the WTR, I shall give Clinical Employment Services Limited / CES Locums 4 weeks written notice.

CRB DISCLOSURE:

CRB Disclosure:

Police Clearance

Disclosure Number: _____ Date of Disclosure: _____

I hereby give my consent Clinical Employment Services Limited to / CES Locums:

- 1. To carry out Criminal Record Check with the CRB on my behalf
- 2. Disclose my CRB information to my potential employer prior to starting a job with that employer
- 3. Communicate with the registered body that had obtained the CRB Disclosure on my behalf to clarify my latest CRB status for the employment purposes only

FITNESS TO PRACTICE DECLARATION:

Criminal Record/Rehabilitation of Offenders Act 1974 and Fitness to Practise declaration by the Agency Worker.

Name:

EXEMPTED QUESTION: Do you have any unspent* criminal convictions?

Yes / No (delete as applicable)

If yes, please list your criminal convictions and their dates in a separate sheet. The information you give will be treated in confidence and only taken into account where, in the reasonable opinion of [Clinical Employment Services Limited], the offence is relevant to the post for which you are applying.

Failure to declare a conviction may require us to exclude you from our register or terminate an assignment if the offence is not declared but later comes to light.

Signed:Date:



I CONFIRM THAT I AM 18 YEARS OF AGE OR OVER.

IN SIGNING THIS DECLARATION, I ACKNOWLEDGE THAT NEITHER CLINICAL, NOR IT'S EMPLOYEES HOLD ANY RESPONSIBILITY OR LIABILITY WHATSOEVER FOR THE SERVICES I PROVIDE, NOR THE CONSEQUENCES OF THE PROVISION OF SUCH SERVICES, INCLUDING PERSONAL ACCIDENT, DAMAGE TO THE CLIENT'S PROPERTY etc.

I DECLARE THAT ALL THE INFORMATION I HAVE GIVEN IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

I HAVE READ AND AGREE TO ABIDE FULLY BY THE TERMS AND CONDITIONS OF MEMBERSHIP.

SIGNED: _____

DATE: _____

OFFICE USE ONLY

DOCUMENT	PROVIDED TO AGENCY WORKER	STAFF NAME & DATE
Terms & Conditions for Agency Worker		
Agency Worker Handbook		
Health & Safety Manual		
Interview Sheet		
Photo ID Badge		
CRB Application Form		
Declaration of Health		
BCG Scar Declaration		
COMMENTS		



ACE SAFE

Confidential Work Health Assessment

Your answers to this questionnaire will be **CONFIDENTIAL** to the ACE SAFE team and will not be given to anyone else without your written permission. The purpose of the questionnaire is to assess whether you have any health problems that could affect your ability to undertake the duties of the post you have been offered or place you at any risk in the workplace. We may recommend adjustments or assistance as a result of this assessment to enable you to do the job. Our aim is to promote and maintain the health of all people at work. Before health clearance is given for employment you may be contacted by the ACE SAFE team and may need to be referred to an occupational health advisor or physician.

Please help us to help you by completing the questionnaire as fully as possible. Please complete this form in BLACK pen / typeface and block capitals

Title: Ms / Miss / Mrs / Mr / Dr / Professor:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Surname/Family name:	First name:	
Previous names (if applicable):		
Date of birth:	Proposed Job Title:	
Home Address:		
Post code:	Are you new to working for the NHS? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Mobile:	Tel home:	
Name of GP:	Tel No of GP:	
Address of General Practitioner		
<i>Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006)</i>		
Have you lived continuously in the UK for the last 5 years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If no, please list all of the countries that you have lived in over the last 5 years		
Have you had a BCG vaccination in relation to Tuberculosis?	Approx date of vaccination:	

PREVIOUS EMPLOYMENT IN THE LAST 5 YEARS

Employer	Nature of your work	Start date	Finish date

All staff groups complete this section

1. Do you have any illness/impairment/disability (physical or psychological) which may affect your work?

If **yes**, please give details below or on a separate sheet Yes No

2. Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?

Yes No

If **yes**, please give details below or on a separate sheet

3. Are you having, or waiting for treatment (including medication) or investigations at present? If your answer is yes, please provide further details of the condition, treatment and dates.

If **yes**, please give details below or on a separate sheet Yes No

4. Do you think you may need any adjustments or assistance to help you to do the job?

If yes, please give details below or on a separate sheet

Yes No

5. Do you have any of the following:

Yes No

(a) A cough which has lasted for more than 3 weeks?

(b) Unexplained weight loss?

(c) Unexplained fever?

Have you had tuberculosis (TB) or been in recent contact with open TB?

If **yes**, please give details

6. Immunisation History: Evidence must be supplied in the form of vaccination record card or serology reports

Have you had any of the below immunisations	Yes	No	Dates:
Diphtheria			
Tetanus			
Polio			
M.M.R – evidence of 2 vaccinations or serology reports for Measles, Mumps and Rubella			
Varicella – evidence of 2 vaccinations or serology report for Varicella			
Hepatitis B primary course of 3 vaccines: Please supply evidence of titre level following primary course.			
Hepatitis B boosters: Please supply evidence of titre level following booster.			
Tuberculosis – BCG vaccination Evidence to be supplied either by providing a signed record from occupational health or GP that they have sighted your BCG scar or tuberculin skin test (Heaf Grade 2 or Mantoux 6mm – 15mm).			

ONLY HEALTHCARE WORKERS INVOLVED IN PATIENT CARE / PATIENT CONTACT / BODY FLUID SAMPLE HANDLING COMPLETE THIS SECTION (INCLUDING LABORATORY WORKERS)

Yes No

Have you ever tested POSITIVE for HIV/AIDS?

Have you ever had or tested POSITIVE for Hepatitis B?

Have you ever had or tested POSITIVE for Hepatitis C?

Exposure Prone Procedures (EPP) are those procedures where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissue (e.g. spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times.

EPP staff include: All surgeons (including FY1 and FY2 doctors with a rotation into one of the EPP areas), dental staff, theatre staff, midwives, A&E doctors and nurses.

EPP staff MUST provide documentary evidence of hepatitis B surface antigens, Hepatitis C and HIV status. This must be an identified validated sample (IVS). Health clearance for EPP work cannot be given until these results have been received and processed. IF YOU HAVE PREVIOUS BLOOD RESULTS AND / OR DOCUMENTED EVIDENCE OF RELEVANT VACCINATIONS PLEASE SUPPLY A COPY WHEN YOU SUBMIT THIS FORM.

IF RESULTS ARE NOT AVAILABLE YOU WILL NEED TO BE TESTED AND HEALTH CLEARANCE FOR EPP WORK WILL BE DELAYED UNTIL THESE RESULTS ARE PROCESSED. You will be asked to show formal photographic ID i.e. valid driver's licence, passport for this procedure. This is to comply with the Department of health's standard for Identified Validated samples (IVS).

Yes No

Will you be performing exposure prone procedures (EPP)?

Will you be working on a renal unit?

Healthcare workers who perform EPPs have a legal duty to inform the ACE SAFE team if they suspect or know that they are carriers of HIV, Hepatitis B or Hepatitis C.

DECLARATION

I declare that the answers to the above questions are true and complete to the best of my knowledge and belief. I give permission for a member of the ACE SAFE team to communicate with my own general practitioner, or any other health professional, if further information is required and for that GP or healthcare professional to give details of my clinical condition or other relevant information to the OH advisor/physician at the ACE SAFE.

I understand that I shall be contacted to obtain my fully informed consent **before** any report is requested and that under the Access to Medical Reports Act, 1988:

- I have the right to see the report before it is sent.
- I am entitled to ask the doctor to amend or modify information which I consider is inaccurate.
- I have 21 days from notification to seek access to the report.

*I wish to seek access to this report/I do not wish to seek access to this report

(Please delete as appropriate)

Signed

Date

.....

I understand that if any recommendations to my employer are necessary as a result of this Work Health Assessment, ACE SAFE will discuss the recommendations with me before making them to my employer.

*I give consent for ACE SAFE to make recommendations to my employer, without me having seen a written copy of the recommendations first.

OR

*I would like to see a written copy of any recommendations the Health and Work Centre may make to my employer before they are sent to my employer.

* delete one of the above statements before signing below.

Signed

Date

.....