



GENERAL PERSONAL 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:

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: _____

HOW DID YOU HEAR ABOUT US:

PRINTED ADVERT	<input type="checkbox"/>	_____	ONLINE REGISTRATION	<input type="checkbox"/>	_____
WEB ADVERT	<input type="checkbox"/>	_____	AGENT	<input type="checkbox"/>	_____
WORD OF MOUTH	<input type="checkbox"/>	_____	OTHERS	<input type="checkbox"/>	_____

IMMIGRATION STATUS

Nationality: _____ Type of the current visa: _____

Proof provided: _____ Valid from _____ To _____

TYPE OF ENGAGEMENT

Please tick as appropriate and provide information accordingly:

PAYE <input type="checkbox"/>	Please provide: National Insurance Number, Bank Account Number, Sort Code
Self Employed <input type="checkbox"/>	
Limited Company <input type="checkbox"/>	Please provide: Company Name, Company Registration Number, Date of Registration, Bank Account Number, Sort Code



ABOUT PROFESSION

<u>HOSPITAL DOCTORS;</u> <i>Please specify your preferences bellow:</i>			
GRADE	SPECIALITY	SUB-SPECIALITY	
<u>GENERAL PRACTITIONERS;</u> <i>Please tick as appropriate:</i>			
SPECIALITY	<i>tick</i>	COMPUTING SYSTEM	<i>tick</i>
DAY SURGERY		EMIS	
OOH SERVICE		VISION	
HMPS		ADASTRA	
FME		SYSTEM 1	
MoD		TOREX	
IRC (Immigration Removal Centres)		OTHER	
<u>PHARMACY</u>			
<i>Please tick and specify as appropriate</i>			
Qualified and Registered Pharmacist			
Technician or Dispenser			
Other , please specify			
PREFERENCES:			
Hospital (Please specify dispensary or ward)			
Community (Please specify independent or Chain)			
HMPS			
Other (Please specify)			
<u>SPECIAL TRAINING;</u>			
<i>Please specify if you have taken any special trainings and provide proof such as (MUR, CPPE, etc)</i>			
<u>COMPUTING SYSTEMS;</u> <i>Please specify computing systems you are familiar with</i>			



DOCUMENTS CHECK LIST

<u>ORIGINAL COPIES MUST BE VERIFIED</u>	YES	NO	NOTES
UP TO DATE CV			
PROFESSIONAL BODY CERTIFICATE OF REGISTRATION			GMC, NMC OR RPSGB
PROOF OF SPECIALIST REGISTRATION			GP REGISTER OR THE SPECIALIST REGISTER
PROOF OF IMMIGRATION STATUS			
PHOTO ID (PASSPORT, ID CARD, DRIVING LICENSE)			
PROFESSIONAL INDEMNITY INSURANCE			
BASIC AND POSTGRADUATE QUALIFICATIONS			
CERTIFICATES OF GENERAL TRAININGS LIKE (MANUAL HANDLING, HEALTH AND SAFTY ETC.)			
<u>PROOF OF PROFESSIONAL SPECIALIST TRAININGS SUCH AS:</u>			
DRUG MISUSE			
ALS, APLS, CALS, etc.			
SECTION 12			
FAMILY PLANING			
OTHER, PLEASE SPECIFY			
<u>PROOF OF INCLUSION ON A UK MEDICAL PERFORMERS LIST:</u>			
ENGLAND			
SCOTLAND			
WALES			
OCCUPATIONAL HEALTH QUESTIONNAIRE AND DECLARATION			
<u>ORIGINAL PROOF OF THE FOLLOWING MUST BE VERIFIED:</u>			
HEPATITIS B			
HEPATITIS B SURFACE ANTIGEN (EPP ONLY)			
HEPATITIS C (EPP ONLY)			
RUBELLA			
VARICELLA			
BCG / TUBERCULOSIS			
MEASLES			
MUMPS			
HIV (EPP ONLY)			

STATE REGISTRATION WITH PROFESSIONAL BODY IN THE UK:

GMC
 NMC
 RPSGB
 HPC
 OTHER

REGISTRATION NUMBER:

DATE OF REGISTRATION:

I undertake that I will inform Clinical Employment Services Limited / CES Locums of any changes to my registration status with the professional body also of any allegations, suspensions and any related issues.

I understand that Clinical Employment Services Limited / CES Locums will liaise and communicate with the professional body regarding any complaints about my professional conduct accrued during any work engagement through CES Locums.

PROFESSIONAL INDEMNITY INSURANCE

Do you have Professional Indemnity Insurance?

Yes
 No

If the answer is yes, please provide details:

INSURAR:

MEMBERSHIP NUMBER:

ISSUE DATE:



CRIMINAL RECORD

Type of Criminal Record Clearance: CRB Disclosure: Police Clearance

Reference of Clearance Certificate: _____ Date of Certificate _____

Carried by (Registered Body) _____

EXEMPTED QUESTION: Have you ever had a spent or unspent criminal conviction/s Yes No
If the answer is yes, please provide details on a separate sheet.

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

1. To carry out Criminal Record Check with the CRB on my behalf
2. Disclose my CRB information to Clients.

I understand that is my obligation to inform Clinical Employment Services Limited / CES Locums of any eventual changes to my Criminal Record Status immediately

SIGNATURE

DATE

Statement on Working Time 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.

DECLARATION

- I CONFIRM THAT I AM 18 YEARS OF AGE OR OVER.
- I ACKNOWLEDGE THAT NEITHER CES LOCUMS, 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 WORKERS OF CLICAL EMPLOYMENT SERVICES LIMITED T/A CES LOCUMS.

SIGNED: _____

DATE: _____



DECLARATION OF HEALTH			
The contents of this form will remain confidential to our Occupational Health screening service and will not be disclosed to anyone without your written consent.			
1. Personal Details			
Surname:		Forename(s):	
Any other surnames you have had:		Male / Female	
Title: Mr / Mrs / Miss / Ms / Doctor / Professor		Date of Birth:	
Address:			
Post Code:			
Contact Details:			
Home:		Mobile:	
Work:		Email:	
2. Position applied for –		Please √ all boxes which may apply	
The specialities that I may be working in whilst an Agency Worker:			
<input type="checkbox"/> General Medicine	<input type="checkbox"/> Orthopaedics	<input type="checkbox"/> PICU/NICU	
<input type="checkbox"/> General Surgery	<input type="checkbox"/> Accident & Emergency	<input type="checkbox"/> Oncology	
<input type="checkbox"/> Theatre	<input type="checkbox"/> Renal	<input type="checkbox"/> Midwifery	
<input type="checkbox"/> ITU	<input type="checkbox"/> Paediatrics	<input type="checkbox"/> Mental Health	
<input type="checkbox"/> Cardio/Thoracic	<input type="checkbox"/> Community	<input type="checkbox"/> Other please state below	
This job may involve:			
<input type="checkbox"/> working with human blood, tissues, fluids		<input type="checkbox"/> handling animal products	
<input type="checkbox"/> working with respiratory sensitisers or laboratory allergens		<input type="checkbox"/> exposure to ionising radiation	
<input type="checkbox"/> handling patients		<input type="checkbox"/> genetically modified organisms	
<input type="checkbox"/> handling heavy goods		<input type="checkbox"/> exposure prone procedures	
<input type="checkbox"/> food handling		<input type="checkbox"/> regular VDU usage	
<input type="checkbox"/> driving		<input type="checkbox"/> overseas travel	
<input type="checkbox"/> working night shifts			
For night shift workers: How long have you been working nights? What type of work?		For night shift workers: Have you suffered any health problems that are directly related to working night shifts? Please state:	
3. Work Related History		YES	NO
Have you been absent from work or full time study due to ill health during the last 12 months?			
Have you ever left or been denied a job on health grounds?			
Have you ever been denied driving licence on health grounds?			
Have you ever suffered from any work related health conditions?			
Have you ever had an accidental sharps injury or exposure to blood/bodily fluids with broken skin or mucous membranes? If YES please state opposite: <ul style="list-style-type: none"> • Date of the incident • Status of source if known • Details of treatment given at time of injury • Details of follow up blood test results / surveillance 			



4. Health History:			
Do you have or have you had in the past:	YES	NO	Please give details:
Conditions of the lungs? Asthma / bronchitis / pleurisy / tuberculosis / other chest complaints / coughing up blood / shortness of breath?			
Conditions of the heart? High blood pressure / heart attacks / angina?			
Nervous system disorder? Blackouts / epilepsy / muscular weakness / paralysis?			
Migraine or persistent headaches?			
Conditions of the digestive system? Irritable bowel syndrome / liver complaints / jaundice / colitis / gastric/duodenal ulcer?			
Conditions of the bones, joints and limbs? Arthritis / rheumatism / back problems / neck or shoulder problems / sciatica / upper limb disorder / tennis elbow / any other conditions?			
Allergies? Including allergies to drugs, animals and pollens			
Skin conditions? Eczema / dermatitis / psoriasis / recent infection / skin cancer?			
Gland trouble? Diabetes / thyroid – overactive / underactive?			
Eye conditions? Restricted vision / glaucoma / iritis / any other conditions?			
Ear conditions? Restricted hearing / tinnitus / ear infections?			
Alcohol or drug problems? Problems related to alcohol or drug usage or dependency?			
Mental illness and/or stress related problems? Nervous breakdown / mental fatigue / anxiety / depression / panic attacks / significant sleep disturbance / stress related problems / eating disorders / self harm / any other conditions?			
Have you consulted a specialist or need any operations other than already stated?			
Have you spent any time in hospital other than already stated?			
Have you consulted your GP in the last 12 months?			
Are you receiving medical treatment at the present time?			
Do you take any regular medication?			
[1] Are you aware of having any disability that is covered by the Disability Discrimination Act?			
Have you any disabilities affecting sight, hearing, standing, sitting, walking, lifting, driving, stair climbing, use of the hands or ability to carry out any work indicated in section 2?			
Have you been in contact with MRSA? If Yes – did you contact Occupational Health? Please detail the treatment you received and state whether you have been cleared. You are required to inform The Agency immediately should you come into contact with MRSA as stated in your staff member handbook.			
Have you any other health issues that have not been mentioned above or about which you would like to provide further details?			

[1] Disability Discrimination Act 1995. You would be regarded as disabled if you have a medical condition that has lasted or is likely to last for more than one year and is sufficient to impair normal day-to-day activities. We are committed to making reasonable adjustments to facilitate individuals with disabilities. Disability does not preclude consideration for employment.



5. Vaccination History

Have you had the following immunisations or tests – to reduce the need for further blood tests, please provide a laboratory report or certificates signed and dated for your GP / Vaccination Centre or Occupational Health Department as evidence of all the immunisations as listed below: **Please note that Hep B titre levels are required every 5 years.**

Immunisations and Blood Tests	YES	NO	Dates and Results (attach evidence)
Hepatitis B primary course			
Hepatitis B booster/s			
Hepatitis B antibody blood test			
Hepatitis B Surface antigens (if working in EPP)			
Hepatitis C (if working in EPP)			
HIV dual screen (if working in EPP)			
Varicella – serology report required			
Rubella – serology report required			
Measles – serology report required			
Mumps – serology report required			
Diphtheria			
Polio			
Tetanus			
TB skin test e.g. Heaf test/Mantoux			
BCG (protection against TB) – scar to be sited by and Occupational Health Professional.			

Clinical staff - health care workers who perform exposure prone procedures must inform Occupational Health if they suspect or know they are HIV positive.

DECLARATION FROM AGENCY WORKER

I declare that the information give within this declaration of health is true and complete to the best of my knowledge. I understand and accept that I may be required to attend for an Occupational Health Assessment.

I understand and accept that further medical information may be requested from my doctor if considered necessary.

I understand that making false statements or failure to declare health problems could lead to removal from the Agency’s register. I agree to update this declaration of health on an annual basis.

PRINT NAME:	SIGNATURE:	DATE:
GENERAL PRACTITIONER DETAILS		
GP Name:		
Address:		
Post Code		



**Declaration by Occupational Health Nurse Advisor for
Ace SAFE re: Viewing of BCG Scar.**

Candidate Name:	Date of Birth:	
Please tick yes or no to the following questions:		
Question:	Yes	No
Do you suffer with any chest problems, e.g. recurrent cough, breathlessness?		
Have you had Tuberculosis or contact with Tuberculosis?		
Do you have a family history of Tuberculosis?		
In the last 12 months have you had a cough last for more than 3 weeks?		
In the last 12 months have you coughed up blood?		
In the last 12 months have you had any unexplained weight loss, fever or night sweats?		
Have you had a BCG vaccination?		

For Occupational Health Use:

Candidate Name:	Date of Birth:	
I confirm that I have viewed a BCG scar on the above candidate:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The scar is located:		
PRINT NAME:	Signature:	
Qualification:	Date:	

If no BCG scar is present candidate must undergo tuberculin skin test and results evidenced as having protection against TB before being assigned to work in the NHS.

Official Stamp required:
