

PERSONAL DETAILS

Please affix 2x
Passport Photographs.

Title: _____

First Name: _____

Known As: _____

Middle Name(s): _____

Last Name: _____

Maiden Name: _____

Gender: Male Female

Nationality: _____

Marital Status: _____

How Did You Hear Of Us: _____

Address: _____

Town/City: _____

County: _____

Postcode: _____

Email: _____

Tel: Home: _____

Tel: Mobile: _____

Work Status: _____

National Insurance No: _____

Passport No: _____

Passport Expiry Date: _____

Driving License: Yes No

Car Owner: Yes No

Please specify times at which you are not to be contacted: _____

Is it ok to contact you at work: Yes No

CAREER HISTORY

Please confirm your career history details for the last 10 years. Please list using most recent first.

Employer:			
Address:			
Phone number:			
Date started:		Date left:	
Job title:		Full or part-time:	
Grade:		Dept/Ward:	
Reason for leaving:			

Employer:			
Address:			
Phone number:			
Date started:		Date left:	
Job title:		Full or part-time:	
Grade:		Dept/Ward:	
Reason for leaving:			

Employer:			
Address:			
Phone number:			
Date started:		Date left:	
Job title:		Full or part-time:	
Grade:		Dept/Ward:	
Reason for leaving:			

QUALIFICATIONS & TRAINING

Secondary Education

School Name, Address and Date attended	Qualification Achieved

Further Education and Training

University/College and date attended	Type of course	Subjects	Qualification or class of degree

Occupational qualifications

College/Institute, NVQ or other name and date attended	Qualification/Level

You should supply any certificates such as ENB or Diplomas etc -please note that we require manual handling/CPR certifications that have been updated in the last 12 months.

NURSES APPLICATION FORM

BAND (NEW TERMINOLOGY) 1-8							
2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	
TYPE OF WORKER							
RNLD <input type="checkbox"/>	RHV <input type="checkbox"/>	EN <input type="checkbox"/>	RSCN <input type="checkbox"/>	RFN <input type="checkbox"/>	RM <input type="checkbox"/>	RGN <input type="checkbox"/>	
RMN <input type="checkbox"/>	RH <input type="checkbox"/>	ENM <input type="checkbox"/>	ENG <input type="checkbox"/>	ENMH <input type="checkbox"/>	RNMH <input type="checkbox"/>		
RECORDABLE QUALIFICATIONS							
RN1-1 st Level General Nursing					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
RN2-2 nd Level General Nursing (England & Wales)					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
RN3-1 st Level Mental Illness					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
RN4-2 nd Level Mental Illness (England & Wales)					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
RN5-1 st Level Learning Disabilities					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
RN6-2 nd Level Learning Disabilities (England & Wales)					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
RN7-2 nd Level Nurses (Scotland & Wales)					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
RNB-1 st Level Sick children					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
RN9-Fever Nurse					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
RN12-1 st Level Adult Learning					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
RN13-1 st Level Mental Nursing					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
RN14-1 st Level Learning Disability					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
RN15-1 st Level Children					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
MRM-Midwifery					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
HRHV-Health Visiting					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPAN-Special Practitioner Adult Nursing					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPMH-Special Practitioner Mental Health Nursing					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPCN-Special Practitioner Children's Nursing					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPLD-Special Practitioner Learning Disabilities					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPGP-Special Practitioner General Practice					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPCM-Special Practitioner Community Mental Health					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SCLD-Special Practitioner Community Learning Disabilities					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPCC-Special Practitioner Community Children's Nursing					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPOH-Special Practitioner Occupational Health					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPSN-Special Practitioner School Nursing					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPDN-Home/District Nursing with integrated nurse prescribing					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
V100-Independent Nurse Prescribing V100					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
V200-Extended Nurse Prescribing V200					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
V300-Extended/Supplementary Prescribing					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
TTTT-Lecturer/Practice Educator					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
MIDWIFES ONLY							
Practising					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Intention to practice completed (you cannot work without this as a Midwife)					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Expiry Date:							
Mentor Name & Address:							

MEDICAL HISTORY

Have you ever suffered from any of the following?

Diabetes	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Asthma/Hay fever	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Bronchitis/Pneumonia/Pleurisy	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Epilepsy	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Headaches/Migraine	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Back problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Recurrent infections	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you taking any prescription drugs?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

If you have answered yes to any of the above questions please give details on separate paper attached to the back of the application form.

Have you ever been vaccinated, immunized or tested for/against any of the Following?

Varicella	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Tuberculosis including BCG	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Heaf, Mantoux or Tine	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Rubella (German Measles)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Poliomyelitis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Hepatitis B	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Hepatitis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
HIV	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Tetanus	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Typhoid	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Any Other Please State:		

Name Of GP: _____

Address: _____

Postcode: _____

Telephone: _____

REFERENCES

Arise Care requires 2 professional references.

It is essential that you have had professional dealings with both of your references within the last 2 years.

Name Of Referee:	_____	Place Of Work	_____
Position	_____		
Work Address:	_____		
Country:	_____	Postcode:	_____
Telephone Number:	_____	Fax:	_____
Email:	_____	Mobile Phone:	_____

Name Of Referee:	_____	Place Of Work	_____
Position	_____		
Work Address:	_____		
Country:	_____	Postcode:	_____
Telephone Number:	_____	Fax:	_____
Email:	_____	Mobile Phone:	_____

OPT-OUT AGREEMENT

DEFINITIONS

In this Agreement the following definitions apply:-

“Assignment” means the period during which the Temporary Worker is engaged in services to a Client.

“Client” means the person, firm or corporate body that has engaged the services of the Temporary Worker.

“Employment Business” means Arise Care.

“Temporary Worker” means a Qualified Nurse, care assistant or other Temporary Worker.

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

THE AGREEMENT

The Working Time Regulations of 1998 state that a Temporary Worker shall not work on an Assignment with a client in excess of the Working Week unless they agree in writing that this limit should not apply.

The Temporary worker, by signing the declaration below, agrees that the Working Week shall not apply to their Assignments.

The Temporary Worker can end this Agreement at anytime by giving the Employment Business 14 days notice in writing. After the 14 day notice period has expired the Working Week shall apply immediately.

It should be noted, that any notice ending this Agreement does not mean that a Temporary Worker has ended an Assignment with a Client.

These laws are governed by English Law and are subject to the jurisdiction of the English Courts.

THE DECLARATION

I have read and fully understand the above OPT OUT AGREEMENT.

I hereby consent that the Working Week limit shall not apply to my Assignments.

I understand that I can end this Agreement by giving the Employment Business 14 days notice in writing.

SIGNED :

PRINT NAME:

DATE:

NEXT OF KIN

NEXT OF KIN DETAILS

FULL NAME:

RELATIONSHIP TO TEMPORARY WORKER:

HOME TELEPHONE:

MOBILE NUMBER:

ADDRESS:

DISCLOSURES

Rehabilitation of Offenders Act

Due to the nature of the work for which you are applying, this post is exempt from the provisions of section 4.2 of the rehabilitations of offender’s act 1974 (exemption order 1975). Applicants are therefore, not entitled to withhold information about convictions which for other purposes are ‘spent’ under the provisions of the act and in the event of employment. Failure to disclose such convictions could result in dismissal or disciplinary action. Any information given will be completely confidential and will be considered only in elation to an application for positions in which the order applies, and should be entered at the end of any particulars you give in support of your application.

A copy of our written policies is available upon request. A criminal record will not necessary be a bar to obtaining a position.

Have you ever been convicted of a criminal offence? YES NO

Do you have any spent or unspent criminal convictions or cautions? YES NO

With an enhanced disclosure, under section 4.2 of the rehabilitation of offenders act 1974 (exemption order), all previous cautions, warnings and convictions will always be detailed regardless of how long ago

Any conviction, caution, reprimand will require a written statement of each and every event and how it does not affect your suitability for the role you are applying for.

Have you supplied additional information with this application for any spent/ unspent convictions, cautions or reprimands?

YES NO

Have you ever been involved in court proceedings?

YES NO

Please give any additional information which you think may be relevant in support of your application on a separate page.

IF YOU HAVE A CONVICTION/CAUTION RELATING TO A VIOLENCE OR THEFT OFFENCE, WE WILL BE UNABLE TO PROGRESS WITH YOUR APPLICATION.

DECLARATION

I confirm that the information I have provided in support of this application is complete and true and understand that knowingly to make a false statement could be a criminal offence.

Signature: _____ Date: _____

I consent to Arise Care checking the details I have provided against the various data sources in order to verify my identity and process the application. These details may be recorded and used to assist other organisations for identity verification purposes such as the CRB, regulatory bodies such as NMC or GSCC.

Signature: _____ Date: _____

Arise Care retains the right to hold this application and any other data required to process this application (whether in the UK, European Union or elsewhere) and keep for as long as necessary in line with the data protection act.

NURSES APPLICATION FORM



Please send the completed application form to the following address:-

The Recruitment Manager
Arise Care Ltd.
93, Walnut Avenue,
Southampton
Hampshire, SO18 2QU.
United Kingdom

BUILDING SOCIETY /BANK DETAILS			
Bank Name			
Bank Address			
Building Society Bank Roll			
Account Holder's Name			
Sort Code		Account No	

I.....authorise Arise Care to pay my weekly wages into the above Bank Account and I will notify Arise Care if changes occur to my details.

Signed:..... Date:.....

We try to make our registration process as swift and painless as possible but we are sure that you understand that owing to the sensitive nature of your profession that our checks have to be thorough.

PLEASE CONTACT US ON 02381949893
Thank you.