**Trained Application**

Please complete in Black Ink

|  |  |
| --- | --- |
| Surname: Mr/Mrs/Ms/Miss | Forename: |
| Maiden Name: | Date of Birth: |
| Current Address: | Postcode: |
| Telephone Number: | Mobile Number: |
| NMC Pin Number:NMC Expiry Date: | Union Membership: |
|  |
| Next of kin: *(if this changes it is your responsibility to inform Initial as soon as possible)* | Relationship: |
| Address: | Telephone Number:Mobile Number: |
|  |
| PVG Reference Number: | Revalidation Date: |
| Qualifications & Dates: | Current E Mail Address:NI Number: |
| Any other professional Qualifications: | Moving & HandlingPlace: Date: |
| Mode of Transport: Car/ Bus/Bike/Train |
| Employment Telephone Number: | Are you contactable at work? Yes [ ] No [ ] |

**Employment History**

Please add your Full employment history with most recent first:

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| **Place of Employment** | **From/To** | **Position Held** | **Reason for Leaving** |
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**Please tick the boxes for the relevant skills you have in the different fields**.

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| Frail elderly |  | Insulin administration |  |
| Dementia |  | IV drug administration |  |
| Young chronic sick |  | Flu vaccination |  |
| Learning disabilities |  | Venepuncture |  |
| Multiple sclerosis |  | MDS drug system |  |
| Diabetic |  | Nomad |  |
| Epilepsy |  | Blister pack |  |
| Parkinson disease |  | POD system |  |
| Cancer care |  | Trolley (bottle and pill system) |  |
| Alcohol Dependence |  | PEG feed |  |
| Orthopaedic conditions |  | Care of a peg tube |  |
| Alzheimer’s |  | Super pubic catheter care |  |
| Vascular disease |  | Catheter care |  |
| Bipolar clients |  | Basic Life support |  |
| Manic depression |  | Advanced life support |  |
| Visual impairment |  | Moving and handling |  |
| Hearing Impairment |  | Health and safety |  |
| Challenging behaviour |  | Fire prevention |  |
| Downs syndrome |  | First Aid |  |
| Head Injury |  | Tissue Viability |  |
| Brain Injury |  | Dressings |  |
| Stroke |  | Care planning |  |
| Schizophrenia |  | Mentorship |  |
| Mental health conditions |  | Supervision |  |
| Crohn’s disease |  | Pulse |  |
| Colitis |  | Blood Pressures |  |
|  |  | BM checks |  |
|  |  | Pressure area care |  |
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| PVG Application Form?Yes [ ] No [ ] | I have been given a Health Declaration form?Yes [ ] No [ ] |
| Please provide details of any contact with MRSA in care home setting: |
| Work Permit Details: | Expiry Date: |

Have you ever been convicted of any offence? Yes [ ] No [ ]

You must answer this question as by virtue of the Re-Abolition of Offences Act 1974 Exception. Order 1975 schedule 1 part 1 clause 13 – convictions that might but for this but for this provision be regarded as spent and **MUST BE DISCLOSED**.

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| If you have answered **Yes** to the above, please provide the following information:Date of Offence:Offence Details:Any other relevant facts: |

|  |
| --- |
| Are there any outstanding charges against you, which remain to be dealt with by any court?If so, please provide details:Date due in court:Charge details and any other facts: |

I confirm that there are no UK immigration control restrictions limiting my staff conditions of stay or freedom to work in this country.

The information I have provided is true and accurate and I have read the conditions and understand that if accepted, I will abide by the conditions laid out.

I also confirm that I have completed this application form to the best of my ability by me and I have read the conditions of service and a copy has been given to me.

I certify that the answers are true and I accept that any errors or emissions made by me can result in the termination of my contract with Initial Healthcare.

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| **I declare that to the best of my knowledge the information given is correct.**Signature: Date: |

Branch to sign confirmation of details in application after interview with applicant.

Branch Signature Date:

**Bank Details for Wages**

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| --- | --- |
| **Name of Bank** | **Bank Address** |

|  |
| --- |
| Account holders Name (as it appears on your Bank account) |

## Account Number

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
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## Sort Code

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| --- | --- | --- |
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Please provide two professional references, which should be current employer and most recent

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| **1st Referee**Name: Address:Telephone Number: |

|  |
| --- |
| **2nd Referee**Name: Address:Telephone Number |