

Dear Colleague,

Thank you for registering with Advantage Healthcare, we look forward to this being the beginning of a long and mutually beneficial relationship.

At Advantage we value your individuality and professionalism. Our pledge is simple – no one works harder on your behalf to secure top placements nationwide.

As one of the leaders in our field, we are committed to offering you an unbeatable package of benefits including:

- Excellent rates of pay
- Paid annual leave
- Paid maternity leave
- More flexibility
- Access to a stakeholder pension
- Paid sick leave
- Personal, friendly service
- More choice

All of which helps you to ensure you have total control over your career.

To register, please print off this document, read through this letter and follow the instructions outlined, returning the pack to us with all the elements included – we have provided a checklist for you to check each document off as you put it in the envelope, just to make sure we have everything we need to get you registered, out and working as soon as possible – don't forget to include your speciality sheet which can be printed out from the same website page.

Once your information is with us, we will contact you to confirm receipt and to discuss relevant locum positions.

If you have any queries regarding the enclosed information please do not hesitate to contact one of the team on 01924 361113.

We look forward to welcoming you to Advantage!

Yours sincerely

The Advantage AHP Team!

Registration Checklist

Please check off the following items as you fill them out and place them in your envelope to return. Please note, all original documentation you supply will be returned to you.

- Updated Curriculum Vitae (*within the last year, please can you sign and date each page*)
- Completed registration form
- Completed locum declaration form
- Completed asylum and immigration form
- Updated Referees: relevant to the speciality/s which you have practiced within the past year
- Two passport sized photographs authenticated with a signature on the reverse from a professional third party
- Completed Pre-employment Health Questionnaire. (*The Health Questionnaire is treated in the strictest of confidence. There is no charge to you for this screening. Please return in an envelope marked Confidential Medical Information*)
- A copy of your Post Graduate Qualifications/GMC or HPC Certificate/MDU or MPS Certificate/ALS & PALS Certificate/JCPTGP/SHA Listing/British Casting Certificate/Certificate of Competence
- Proof of current immunisation status (*advice letter regarding immunisations is enclosed*)
 - Hepatitis B: dated evidence of immunity and titre levels
 - Hepatitis C: dated evidence of/or screen for immunity
 - Rubella: dated evidence of/or screen for immunity
 - BCG: dated evidence of/or screen for immunity
 - Varicella: dated evidence of/or screen for immunity (*form enclosed*)
- A signed copy of our Terms & Conditions (*please take a copy for your records*)
- A signed copy of the 48 hour Opt Out Agreement (*please take a copy for your records*)
- One of the following original documents showing your National Insurance number:
 - a payslip from your previous employer
 - a P45
 - a P60
 - a NINO card
 - a letter from a government agency.
- Enhanced Criminal Records Bureau Clearance.
(*If you already have a clearance certificate, please forward the original certificate, which will be returned to you. Should you be unable to provide the above please send a **certified** copy of your clearance). Alternatively you can obtain CRB clearance through Advantage Healthcare. Please see enclosed letter as regards CRB procedure).*
- Your Original Passport, Driving License and/or Birth Certificate.
(*The original documents will be returned to you by Special Delivery*).

Advantage Healthcare Group Limited

St Johns Business Centre 18-20 St Johns North Wakefield WF1 3QA

Telephone: 01924 371 000 Fax 01924 368 000 Email:doctors@advantagehealthcare.com Web@www.advantagehealthcare-doctors.com

Registered Company address: Grosvenor House, Central Park, Telford, Shropshire, TF2 9TW Company Registration No. 2385366.
Registered with The Commission for Social Care Inspection, St Nicholas Buildings, St Nicholas Street, Newcastle upon Tyne NE1 1EB
The company acts as an agent for Advantage Healthcare Group Limited

Allied Health Professionals

St Johns Business Centre
18-20 St Johns North
Wakefield WF1 3QA

Tel 01924 371000
Fax 01924 368000

Attach
photograph
x 2

Allied Health Professionals registration form

Please return your completed registration form to the address above

Which of the following applies to you?

- | | | | | | | | |
|----------------------|--------------------------|------------------------|--------------------------|-----------------|--------------------------|-----------------------------|--------------------------|
| Audiologist | <input type="checkbox"/> | Chiropodist/Podiatrist | <input type="checkbox"/> | ODP | <input type="checkbox"/> | Plaster Technician | <input type="checkbox"/> |
| Biomedical Scientist | <input type="checkbox"/> | Dietician | <input type="checkbox"/> | Phlebotomist | <input type="checkbox"/> | Radiographer | <input type="checkbox"/> |
| Cardiac Technician | <input type="checkbox"/> | Occupational Therapist | <input type="checkbox"/> | Physiotherapist | <input type="checkbox"/> | Speech & Language Therapist | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | Please specify | | | | | |

Please state qualification | Please enclose copy of certificate

Please state current grade and point scale |

1 Personal details

Title	Surname	Maiden name
-------	---------	-------------

Previous surnames (if any) |

Forenames (in full) |

Address |

Post code	Home telephone number
-----------	-----------------------

Mobile telephone Number	Work telephone number ext
-------------------------	-----------------------------

Nationality |

National Insurance number |

Next of kin to be notified in case of emergency

Name |

Address |

	Post code
--	-----------

Telephone number	Work contact number
------------------	---------------------

Relationship to you |

Further medical questions cont ...

Have you ever had problems with:	YES	NO	Please give details	Recovery complete	YES	NO
Raised blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Heart or circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Chest complaints e.g. Asthma, Bronchitis, Pleurisy, Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Chronic indigestion	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Bowel complaints	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Persistent abdominal pains	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Liver disease or jaundice	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, problems with thyroid or other glands	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy, Blackouts or dizziness	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Any mental health problems including: depression, psychiatric treatment, eating disorders or attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Have you received or are you receiving counselling	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Substance misuse including alcohol	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Persistent or recurrent backache or injury	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Neck injury/problems with neck	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Eczema, Dermatitis or other skin disease	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Ear, nose or throat problems	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism, Arthritis or other joint problems	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Vision problems or eye disease	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Hay fever or allergies	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Any other serious illness	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Any operations	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Admissions to hospital	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Serious accidents/visits to casualty. If 'YES' how many times have you attended a casualty department in the last 3 years?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

Note:

If there is a possibility that you may be suffering from an infection, you are requested to discuss this - in confidence with a member of the branch staff before taking up employment.

3 Training and Education

Details of training hospital/establishment	Courses taken	Date from	Date to	Attainment
Details of refresher course(s) or return to practice course(s)				

4 Professional details

The service we give depends on accurate, up to date information. Please keep us informed of all developments in your career.

CPSM/HPC number (Please enclose copy of certificate) | Expiry date |

To assist us in finding suitable work for you, please tick all nursing specialities of which you have significant, post training experience.

- | | | | | |
|---|--|---|-------------|--|
| A & E <input type="checkbox"/> | 24-hour tape analysis <input type="checkbox"/> | Echo <input type="checkbox"/> | NVQ details | Learning Disabilities <input type="checkbox"/> |
| Adult <input type="checkbox"/> | | Elderly Care <input type="checkbox"/> | | Mammography <input type="checkbox"/> |
| Angiography <input type="checkbox"/> | | ENT <input type="checkbox"/> | | Maxillofacial surgery <input type="checkbox"/> |
| Audiology <input type="checkbox"/> | | Fluoroscopy <input type="checkbox"/> | | Medical <input type="checkbox"/> |
| Cardio-thoracic <input type="checkbox"/> | | Haematology <input type="checkbox"/> | | Medical Microbiology <input type="checkbox"/> |
| CCU <input type="checkbox"/> | | Histology <input type="checkbox"/> | | Mental Health <input type="checkbox"/> |
| Cleft palate <input type="checkbox"/> | | Histopathology <input type="checkbox"/> | | MRI <input type="checkbox"/> |
| Clinical Chemistry <input type="checkbox"/> | | ICU <input type="checkbox"/> | | Neo-natal <input type="checkbox"/> |
| Community <input type="checkbox"/> | | Immunology <input type="checkbox"/> | | Neurology <input type="checkbox"/> |
| CT <input type="checkbox"/> | | Industry <input type="checkbox"/> | | NNU <input type="checkbox"/> |
| Cytology <input type="checkbox"/> | | In-patients <input type="checkbox"/> | | Nuclear Medicine <input type="checkbox"/> |
| Dysphagia <input type="checkbox"/> | | ITU <input type="checkbox"/> | | Occupational health <input type="checkbox"/> |

Please give details of any certificates or qualifications you hold. (Please include photocopies of all certificates & copy of your log & competencies)

Please give details of membership of any professional body, including membership number and expiry date. |

(Please enclose copy of certificate/card)

5 General information

Do you hold a current driving licence? YES NO Do you have a current passport? YES NO
Do you have a car available? YES NO Typing/WP experience? YES NO

Please state which languages you speak, including an indication of fluency |

How did you first hear about this agency? |

Are you a member of a Union or Professional Organisation offering Indemnity Insurance for carers and Allieds? YES NO

Body name | Amount of cover |

Policy number | Expiry date | | | | |

6 Preference regarding work

Please specify which types of work you would prefer. You should tick all appropriate boxes. The service we give depends on accurate, up to date information. Please keep us informed of all developments, in your career and work preferences.

Positions part-time full-time sessional on-call

Type of work NHS private hospitals care homes industry

Other, please specify _____

days evenings nights weekends holidays

Do you have any other work commitments? YES NO If yes please give details |

Which areas of work do you wish to specialise in? |

When will you be available to start work? |

Length of time available? (for overseas professionals only) |

Geographical areas in the UK in which you are willing to work? |

Would you be willing to stay in hospital accommodation? YES NO

7 Convictions

Rehabilitation of Offenders Act 1974: State any convictions/offences, information of which you are not entitled to withhold, under the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975, in view of the nature of the work for which you are applying: _____

CRB Statement: If your application is successful you will be required to provide a satisfactory CRB/Scotland Disclosure or equivalent from country of origin if in the UK for less than three months. Advantage Healthcare Group Limited will offer their full support through this process.

Care Standards Act 2003: State any police cautions and incidents with the police, in view of the nature of the work for which you are applying: _____

(This information will be disclosed by the Criminal Records Bureau check which will be required if successful)

Immunisations

Rubella YES Date ____/____/____ NO
 BCG YES Date ____/____/____ NO
 Skin Test for TB YES Date ____/____/____ NO
 Tetanus YES Date ____/____/____ NO
 Chickenpox/Vz. Abs. YES Date ____/____/____ NO
 Poliomyelitis YES Date ____/____/____ NO
 Other *please specify* _____

Hepatitis B

Date of last injection | | | | | | | |

Booster 1st 2nd 3rd

Date of last blood | | | | | | | |

Result |

IUL |

Disability discrimination act

If you suffer from a disability, will you require any adjustments to be made to premises, the duties outlined in the job description, working hours or any other arrangements connected with this post in order to maximise your performance? YES NO

If 'YES' we may be able to consider any reasonable steps so long as they are effective, practicable and affordable.

Please state |

Pregnancy at work regulations

To protect your health at work please indicate, in confidence, to a member of staff if you are pregnant or breast feeding.

Further medical questions

Weight |

Height |

Overleaf you are asked to provide information about a variety of conditions, please describe any other ill health circumstances |

Are you at present taking any medication or receiving any treatment? Give details for the last 12 months |

Please give details of sickness absence for the last 2 years |

GP Name |

GP Address |

9 References

Please give the names of referees, including your present or most recent employer, whom we may approach for a reference (not relatives or friends). A minimum of three years history must be covered.

Can we contact your referees before your interview? 1. YES NO 2. YES NO

1st Referee	Name	Position
Address		
Post code	Telephone number	Known me for _____ years
2nd Referee	Name	Position
Address		
Post code	Telephone number	Known me for _____ years

10 Permanent posts/placement overseas

Are you interested, now or in the future, in locum or permanent posts in the UK? YES NO

Are you interested, now or in the future, in locum or permanent posts overseas? YES NO

11 Confidentiality declaration

Registration implies acceptance of our code of confidentiality.

In the course of your duties you may have access to confidential information about your clients. On no account must information relating to identifiable clients be divulged to anyone other than your branch manager or his/her assistant.

You should not disclose ANY information to your family, friends, or neighbours.

If you are worried by any information you have obtained and consider that you should talk about it to someone else MAKE AN APPOINTMENT TO SPEAK IN PRIVATE to your BRANCH MANAGER.

Failure to observe these rules will be regarded as serious misconduct which could result in disciplinary action.

I have read and I understand the above and I agree to abide by the contents therein.

Signed | Date | | | | | |

12 Passport and work permit details (for professionals from overseas only)

Work permit/visa	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Expiry date											
Passport nationality	Place of issue													
Passport number	Date of issue						Expiry date							
Known restrictions in use														

13 Declaration Section

The information that I have given in this application form is, to the best of my knowledge, complete and accurate in all respects, and I am not aware of any reason why I am not fit for this employment. I understand that knowingly giving false information will disqualify me from registration with this agency.

Signed | Date | | | | | |

Name	Position applied for	Location
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Advantage Healthcare Group Limited aims to be an equal opportunities employer and we select solely on merit irrespective of race, sex, disability etc. In order to monitor the effectiveness of our equal opportunities policy, we request all applicants to provide the information indicated. Please note: Ethnic minority questions are not about nationality, place of birth or citizenship. They are about colour and broad ethnic groups - UK citizens can belong to any of the groups indicated.

Please tick the appropriate category

White	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>	Black African	<input type="checkbox"/>
Indian	<input type="checkbox"/>	Chinese	<input type="checkbox"/>	Black Caribbean	<input type="checkbox"/>
Black other	<input type="checkbox"/>	Other	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>

please specify | please specify |

Locum declaration

(In confidence)

To be completed at the commencement of each locum assignment

I declare that

1. I am feeling well
2. I have the mental and physical capacity to undertake the work required of me as a locum
_____ (Grade and speciality)
from _____ to _____ (Dates)
at _____ (Name of Trust)
3. I am not overtired
4. I believe I do not have any mental or physical infirmity which may pose a risk to patients or staff
5. Please delete/complete as appropriate
 - a I am not taking or awaiting any medical treatment
 - b I am taking the following medication _____
6. I believe that I am not carrying any infection which could pose a risk to patients or other staff
7. In undertaking this locum I will not breach the current guidelines on working hours (New Deal Hours), and agree to abide by all appropriate NHS regulations
8. I understand my responsibility to have all the necessary tests if I think I have, or am carrying, a serious communicable condition and to act on the advice of a suitably qualified colleague about necessary treatment and/or modifications to my clinical practice. I also understand that I must take and follow advice from a consultant in Occupational Health or another suitably qualified colleague if my judgement or performance could be significantly affected by a condition or illness
9. I confirm that I am eligible for employment in this post
10. I confirm that I am not currently suspended from duty or subject to any professional conduct proceedings
11. I declare that I have no criminal conviction or caution, whether 'live' or 'spent', nor have I any criminal proceedings pending against me (if this is not the case, please give details on a separate sheet)
12. I hereby give permission to the employing NHS Trust to undertake a police check on my behalf as appropriate

Locum doctor declaration

Name	_____
GMC number	_____
Signature	_____
Date	____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Asylum and Immigration form

TO ALL APPLICANTS

It is a legal requirement that, before any offer of work can be made, all candidates provide the Company with confirmation of their eligibility to work in the U.K. by providing ONE of the ORIGINAL documents detailed below.

Consequently, would you please tick the appropriate box detailing which document you would intend to bring with you, if you were invited for interview. It would be helpful if you could bring the original document, plus a copy. You should also be aware that a copy of the document will be retained on file.

- A birth certificate issued in the United Kingdom or in the Republic of Ireland, or a certificate of registration or naturalisation as a British citizen.

OR

- A passport which describes the holder as a British citizen or as having a right of abode in the United Kingdom or a passport or other travel document endorsed to show that the holder has indefinite leave to remain in the United Kingdom or has current leave to enter or remain in the United Kingdom and is not precluded from taking the work in question.

OR

- A passport or identity card issued by a State which is a party to the European Economic Area agreement and which describes the holder as a national of a State which is a party to that agreement.

OR

- A letter issued by the Home Office or the Department of Education and Employment indicating that the person named in the letter has permission to take the agency work in question.

ALL CANDIDATES MUST NOTE THAT UNLESS ONE OF THE ABOVE ORIGINAL DOCUMENTS HAS BEEN PRODUCED, NO OFFER OF WORK WILL BE MADE.

Print Name:.....

Signature:.....

Date:.....

Pre-employment Health Questionnaire

(In confidence)



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:

2. Position applied for -

Please ✓ all boxes which may apply

<input type="checkbox"/> GP	<input type="checkbox"/> RMO	<input type="checkbox"/> AHP
<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	

<p>For night shift workers: How long have you been working nights?</p> <p>What type of work?</p>	<p>For night shift workers: Have you suffered any health problems that are directly related to working night shifts? Please state:</p>
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3. Work Related History

	YES	NO	Please give details:
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 a driving licence on health grounds?			
Have you ever suffered from any work related health conditions?			
<p>Have you ever had an accidental sharps injury or exposure to blood/bodily fluids with broken skin or mucus membranes?</p> <p>If YES please state opposite:</p> <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 C			
Varicella (or history of chicken pox)			
Rubella			
TB skin test e.g. Heaf test			
BCG (protection against TB)			
Tetanus within the last 10 years?			
Polio immunisation within the last 10 years?			

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 given 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 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.

In order to verify my fitness to work status, I agree that Advantage Healthcare Group can send my SAFE Fitness Certificate to prospective / existing clients / their Occupational Health Departments.

PRINT NAME:

SIGNATURE:

DATE:

Varicella (chicken pox) Declaration



Name _____

Branch _____

(Please insert your name in block capitals).

I the undersigned confirm that I have had Varicella (chicken-pox) in the past.

Signed _____

Date _____

Please sign and date before returning to the AHP team.

ADVANTAGE HEALTHCARE GROUP OCCUPATIONAL HEALTH SCREENING

ADVICE REGARDING WHAT IMMUNISATIONS ARE REQUIRED FOR DOCTORS

In order to be fit to practise medicine in the UK, current Department of Health guidance requires that you be adequately immunised against infectious disease. Due to the different infection risk, guidelines differ according to whether you currently practise in this country, or are (re) joining UK medical practice. Your immune status may need to be re-checked, once you enter the UK. (The move is towards identified validated samples, which require stringent checks).

Information to help you clarify whether you need further immunisations is given below. Please read this information before completing the Pre-employment questionnaire. If you have already sent your form, you are receiving this, and you should discuss your immunisations with your GP or local OH department.

Infection	Advice for current UK doctors	Extra actions required by new & overseas doctors
Hepatitis B	Immunity is required demonstrating a titre level of >100 miu/ml. If a candidate is a low or poor responder occupational health will advise on areas where you may or may not work. Hep B markers and titre levels are required every 5 years.	Doctors commencing UK practice involving EPPs must demonstrate that they are Surface Antigen negative
Hepatitis C	If performing exposure prone procedures workers must demonstrate that they are negative to Hepatitis C via an identity validated sample	Doctors commencing UK practice should demonstrate non-infectivity, i.e. Hep C RNA negative.
HIV	Workers are required to disclose confidentially if they are or suspect that they are infected with HIV. It may become mandatory that all workers have to demonstrate non-infectivity prior to being able to work however, this is still in consultation with the Department of Health.	Doctors commencing UK practice should demonstrate non-infectivity, i.e. not antibody positive.
TB	All workers are required to demonstrate that they have protection against TB – this can be provided in the following ways: <ul style="list-style-type: none"> • Evidence of BCG vaccination being given i.e. having BCG scar sited by an OH nurse advisor • Heaf test result of Grade 2 or 3. A heaf test result of above 4 will need to have active TB excluded and will probably need to have a chest x-ray.	Those entering from high incidence countries, (e.g. India, Pakistan, South Africa: see WHO website) will require careful screening, (history, BCG, Heaf if no scar, CXR if indicated).

Immunisation Guidance

Rubella	All workers are required to demonstrate immunity to Rubella – this will be in the form of a serology report that states that Rubella antibodies have been detected. If a worker does not have immunity they must have 2 x MMR injections before they are able to work.	
Varicella (Chickenpox)	All workers are required to demonstrate immunity by either declaring that they have had chicken pox in the past or by having a blood test result to show that they have immunity. If immunity can not be demonstrated the worker must have 2 x Varicella injections before they are able to work.	
Polio	Workers should be immunised every 10 years	
Tetanus	Primary course of 3 injections, then a booster after 10 years, and another 10 years which then confers lifelong immunity.	

Non-UK results of immunisations/Laboratory results etc. will not be accepted unless the reports are written in English.

BCG Scar Verification



Name: _____

Branch: Doctors Division - Wakefield

(Please insert your name in block capitals).

I can confirm that I am an RN with OH experience, a GP or work in an NHS OH Dept and that the above named has a BCG Scar evident which I have viewed today.

Signed: _____

Name: _____

Position: _____

Date: _____

Please clarify position, sign and date before returning to the Doctors team.

These terms and conditions are a contract for services between you and Professional Healthcare Services Limited, trading as Advantage Healthcare Group (Advantage Healthcare). Advantage Healthcare is an employment business which specialises in introducing doctors to hospitals ("Clients") who undertake paid activities for Clients on a temporary basis subject to the following terms and conditions ("Work"). This is not a contract of employment.

1 Advantage Healthcare's responsibilities

Advantage Healthcare will:

- 1.1 undertake to use its reasonable endeavours to find you suitable Work in accordance with these terms and conditions. However, you are not obliged to accept the Work offered to you by Advantage Healthcare.
- 1.2 if you accept the Work offered, advise you of the hourly rate of pay for that Work ("Pay Rate"). Advantage Healthcare will use all reasonable endeavours to pay you within 7 business days of you delivering a duly completed time sheet at that Pay Rate for the hours that you have worked in the previous week.
- 1.3 if you have not produced evidence of being a corporate body (as prescribed in relevant legislation) or an exemption certificate (if appropriate), deduct PAYE and National Insurance at the prevailing rates and in accordance with current legislation. If you claim emoluments from Advantage Healthcare without any or all such deductions in accordance with the relevant legislation, you agree to indemnify both Advantage Healthcare and any affected Client against all costs or any claims, assessments, and/or demands in respect of any applicable tax and/or National Insurance contributions and/or revenues which may be payable by you as a result of undertaking Work.
- 1.4 ascertain that you have a current registration with the GMC and/or any other appropriate professional body.
- 1.5 attempt to notify you, as soon as possible, if Work is cancelled either by Advantage Healthcare or the Client on short notice. However, Advantage Healthcare will not accept responsibility, liability, costs and/or expenses for any financial loss or expense, which you may suffer as a result of the cancellation.
- 1.6 obtain references, a criminal records check and all information relating to you that Advantage Healthcare considers relevant prior to you undertaking Work. Advantage Healthcare reserves the right to make such information available to its Clients. However, in all other ways, such information will be held in the strictest of confidence.

2 Your responsibilities

You will:

- 2.1 Work with the Client, its directors, employees and agents and accept lawful directions and instructions of any person acting in a supervisory capacity.
- 2.2 Ensure that you do not exceed guidelines on doctors working hours.
- 2.3 Ensure that you are present at the place of Work during the times and for the total number of hours each day/week as required by the Client subject to clause 2.2.
- 2.4 Take all reasonable steps to safeguard your own safety and the safety of any other person who may be affected by your actions and comply with the Health and Safety policy of the Client.
- 2.5 Observe all lawful rules and regulations of the Client's workplace.
- 2.6 Not engage in any conduct which may be detrimental to the interests of the Client, its staff or its patients.
- 2.7 Deliver to Advantage Healthcare a duly completed weekly timesheet signed by you and the Client detailing the hours worked in the previous week (which shall include details of any breaks taken).
- 2.8 Ensure that at all times you have full professional indemnity insurance and/or indemnity cover ("your Policy") in force.
- 2.9 Not jeopardise your cover under your Policy by breaching any condition of your Policy.
- 2.10 Except where you are advised to the contrary in writing by the Client or Advantage Healthcare, whilst undertaking Work, be responsible for meeting the costs of your own travelling expenses, meals, telephone calls and accommodation and all other expenses ("Expenses"). All such Expenses must be fully discharged by you when either demanded by Advantage Healthcare or the Client or at the very latest, upon completion of your Work assignment. If you fail to pay, Advantage Healthcare reserves the right to deduct from your Pay Rate, a sum equal to any liability you may owe to Advantage Healthcare for Expenses.
- 2.11 Not use any motor vehicles or any other equipment in connection with the Work unless you are properly insured. You shall indemnify and keep indemnified Advantage Healthcare against any damages loss and/or liability incurred by Advantage Healthcare for such use.

- 2.12 Notify Advantage Healthcare of any change in the status of your registration with your professional body. You must maintain full and/or other appropriate registration with the GMC and/or your professional body at all times when undertaking Work. If you fail to maintain registration (or if whilst undertaking Work you are suspended by the GMC or any other professional body such as a Health Authority or similar and/or equivalent body), you will fully indemnify Advantage Healthcare if as a result of your failure to maintain your registration, Advantage Healthcare suffers loss, liability and/or damage.
- 2.13 Advise Advantage Healthcare of any changes to your working hours or the nature of your duties.
- 2.14 Advise Advantage Healthcare if you undertake any other work (which includes training) for any person, firm, company or organisation other than the Client.
- 2.15 Indemnify Advantage Healthcare against any loss costs, claims, fines, demands, awards, expenses and/or liability that it incurs as a result of your acts and/or omissions and/or conduct and/or incompetence, and/or any false and/or incorrect information you have provided to Advantage Healthcare at any time, and/or failing to maintain appropriate registration with the GMC and/or any breach by you of these terms and conditions.
- 2.16 Declare that all the information you provide to Advantage Healthcare be it verbal or written, is true, accurate and complete.
- 2.17 Agree that you will only undertake Work that you are capable, competent and qualified to undertake and shall therefore, refuse to take on any position that you feel is not suitable.
- 2.18 Before commencing Work, provide Advantage Healthcare with confirmation in accordance with relevant legislation that you have not been convicted or cautioned in relation to any criminal offence. In the event that you are convicted and/or charged and/or investigated for a criminal offence you must inform Advantage Healthcare immediately and provide regular reports about the progress and the proceedings.
- 2.19 Inform Advantage Healthcare about any complaint made against you which is relevant to your professional competence or conduct.
- 2.20 Advise Advantage Healthcare immediately if you are offered any employment or engagement by the Client or any third party to whom you are introduced to by the Client and provide details of proposed remuneration.

3 Holidays

- 3.1 Your holiday year shall run from 1 November to 31 October ("Holiday Year")
- 3.2 Your holiday entitlement will be calculated in accordance with the proportion of the Holiday Year that you have worked.

Your holiday entitlement will include bank and public holidays.

- 3.3 Holiday entitlement only arises for the Holiday Year to which it relates. Holiday not taken in the Holiday Year will be lost. You will not be entitled to any pay or compensation for holidays you have not taken within the respective Holiday Year.
- 3.4 Holiday entitlement accrues at an even rate throughout the Holiday Year. You may only take holiday if you have accrued it in accordance with the provisions of these terms and conditions. If you wish to take holiday, you must give Advantage Healthcare notice of at least twice the period of holiday you wish to take. Such notice must be given to Advantage Healthcare in writing. Advantage Healthcare reserves the right to reasonably withhold permission for you to take the holiday you have requested and in accordance with relevant legislation. Notice of any such refusal will be given to you within a period equivalent to the period of holiday you have requested. Advantage Healthcare may require you to take all or part of your holiday entitlement at specified times by giving you notice of at least twice the period of holiday to be taken.
- 3.5 Other than in accordance with applicable legislation you are not entitled to receive payment for a pension and/or time spent not working (for whatever reason).
- 3.6 Where you have received any overpayment or have exceeded your annual Holiday entitlement, Advantage Healthcare reserves the right to recoup the overpayment. Alternatively, Advantage Healthcare may deduct the overpayment directly from any monies due to you.

4 Rest breaks and night workers

- 4.1 Depending on the hours you work each day you may be entitled to a take a break during your working day. If you consider that proper rest breaks are not being provided by the Client, you should raise this matter with Advantage Healthcare promptly.
- 4.2 Depending on the hours you work you may be classed as a night worker. If you are in doubt as to your status, you should contact Advantage Healthcare. If you are a night worker, you must complete a health-screening questionnaire every 12 months. If your health changes in any way following completion of the questionnaire, you must notify Advantage Healthcare immediately and complete a further questionnaire.

5 Termination

- 5.1 Advantage Healthcare reserves the right to terminate these terms and conditions at any time by giving you 1 weeks written notice or statutory notice whichever is the greater.

- 5.2 If there is a break in your Work for a period of more than 7 days, these terms and conditions will be automatically terminated (unless otherwise agreed in writing between you and Advantage Healthcare). If you subsequently restart Work, be it on the same assignment or otherwise, such will be subject to these terms and conditions unless otherwise agreed in writing between you and Advantage Healthcare.
- 5.3 If you are in breach of any of these terms and conditions, Advantage Healthcare reserves the right to terminate immediately by giving written notice.

Signature of Worker _____

Name of Worker _____

Signature of Branch Manager _____

Date _____

Address of Worker _____

Date _____

6 General matters

- 6.1 These terms and conditions will govern the entire agreement between you and Advantage Healthcare to the exclusion of any other terms and conditions other than the agreement between you and Advantage Healthcare in respect of your Pay Rate and the declaration you give to Advantage Healthcare when signing timesheets.
- 6.2 No variation, addition or modification to these terms and conditions shall be binding unless notified to you by Advantage Healthcare in writing.
- 6.3 You will not divulge to any person, nor use for your own or any other person's benefit, any confidential information in relation to the Client and/or Advantage Healthcare, and/or in relation to any of the directors, employees, and/or business activities of Advantage Healthcare and/or the Client. This clause applies throughout the duration of the contract between you and Advantage Healthcare and after termination.
- 6.4 Any waiver by Advantage Healthcare of any breaches of these terms and conditions shall not constitute a waiver by Advantage Healthcare of any subsequent breach of the same or other provision/s.
- 6.5 A person who is not a party to these terms and conditions has no right under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of these terms and conditions but this does not affect any right or remedy of a third party which exists or is available apart from that Act.
- 6.6 The laws of England shall govern these terms and conditions and you shall submit to the exclusive jurisdiction of the English Courts.

OPT-OUT OF 48 HOUR WORKING WEEK AGREEMENT

1. DEFINITIONS

1.1 In this Agreement the following definitions apply:-

“Worker”	Agency Member
“Working Week”	means an average of 48 hours each week calculated over a 26 week reference period.

1.2 References to the singular include the plural and references to the masculine include the feminine and vice versa.

1.3 The headings contained in this Agreement are for convenience only and do not affect their interpretation.

2. RESTRICTION

2.1 The Working Time Regulations 1998 provide that the Worker shall not work in excess of the Working Week unless he agrees in writing that his limit should not apply.

3. CONSENT

3.1 The Worker hereby agrees that the Working Week limit shall not apply.

4. WITHDRAWAL OF CONSENT

4.1 The Worker may end this Agreement by giving 3 months notice in writing.

4.2 For the avoidance of doubt, any notice bringing this Agreement to an end shall not be construed as notice of termination by the Worker.

4.3 Upon the expiry of the notice period set out in clause 4.1 the Working Week limit shall apply with immediate effect.

5. THE LAW

5.1 These Terms are governed by English and Scottish law and are subject to the exclusive jurisdiction of the English and Scottish Courts.

Signed by the Worker: _____ Date: ____/____/____

Print name: _____

CRB Information

Dear Colleague

As you will be aware the Care Standards Act came into effect on 1 April 2002. This Act sets new regulations and minimum standards, which all healthcare providers must adhere to.

It is a requirement of the Act, that all doctors have clearance from the Criminal Records Bureau (CRB) before we can offer locum work.

If you have a recently dated Enhanced CRB Disclosure (dated within the past 12 months), you should send it through to the Doctors Team along with your registration documents.

If you do not have a recently dated CRB Disclosure, you should apply for a new one. To do this you simply need to request a Disclosure Application Form and take it into your local branch (a list is enclosed for your information). **Please call the branch before you go to ensure the authorised signatory is available.** If you encounter any problems completing the form, please talk to the Countersignatory and they will assist you.

The branch must see you with proof of your identity so that they can countersign your application. There is a booklet that will explain how the form should be completed and the identification required.

You will also need to take a **£36.00 cheque**, made payable to Advantage Healthcare Group (disclosure fee made by the Bureau). Please do not take cash.

Please do not post the form with your registration documents. It must be countersigned by a registered Countersignatory before the CRB will accept the completed form for processing.

If you have any questions, please do not hesitate to contact us on the above mentioned telephone number.

Yours sincerely

Shaun Wright
Operations Manager
Advantage Healthcare Group

Advantage Healthcare Group Limited

St Johns Business Centre 18-20 St Johns North Wakefield WF1 3QA

Telephone: 01924 371 000 Fax 01924 368 000 Email:doctors@advantagehealthcare.com Web@www.advantagehealthcare-doctors.com

Registered Company address: Grosvenor House, Central Park, Telford, Shropshire, TF2 9TW Company Registration No. 2385366.
Registered with The Commission for Social Care Inspection, St Nicholas Buildings, St Nicholas Street, Newcastle upon Tyne NE1 1EB
The company acts as an agent for Advantage Healthcare Group Limited

Advantage Locations

CRB forms, and relevant documentation, can be taken to the following Advantage offices for authentication

Please call the office in advance of your visit, in order to ensure the authorised signatory will be there to sign your CRB form

BIRMINGHAM

Rooms 46 – 47
Guildhall Buildings
Navigation Street
Birmingham
B2 4BT
Tel No: 0121 616 1984

BRIGHTON

First Floor
7 Queen Square
Brighton
BN1 3FD
Tel No: 01273 220 660

CAMBRIDGE

Unit 1, Chartwell House
620 Newmarket Road
Cambridge
Cambridgeshire
CB5 8LP
Tel No: 01223 412 020

CARDIFF

14 Museum Place
Cathys Place
Cardiff
CF10 3BH
Tel No: 02920 225 793

COLCHESTER

Unit 3 The Atrium
Phoenix Square
Wyncolls Road
Severalls Business Park
Colchester
CO4 9AS
Tel No: 01206 228 333

CROYDON

Unit 5B 5th Floor
Green Dragon House
64-70 High Street
Croydon
CR0 9XN
Tel No: 0208 256 1990

EALING

Part Ground Floor
84 Uxbridge Road
Ealing
London
W13 8RA
Tel No: 02085 672 495

EDINBURGH

Suites 56 & 57
One St. Colme Street
Edinburgh
EH3 6AA
Tel No: 0845 638 2596

FARNBOROUGH

Suite 1, Ground Floor
7 Alexandra Road
Farnborough
GU14 6BU
Tel No: 01252 376 123

FYLDE COAST

First Floor
18 St Georges Road
Lytham St Annes
Lancashire
FY8 2AE
Tel No: 01253 788 344

GLASGOW

3 Somerset Place
Glasgow
G3 7JT
Tel No: 0141 332 5868

HALIFAX

Office Suite E230
Dean Clough Mills
Halifax
HX3 5AX
Tel No: 01422 382 323

HARROGATE

Ground Floor
3 Devonshire Place
Harrogate
HG1 4AA
Tel No: 01423 528 090

IPSWICH

Unit 3
The Revetts Building
53 – 67 Norwich Road
Ipswich
IP1 2EP
Tel No: 01473 221 422

LEEDS

C.G.N.U. House
Lower Ground Floor
Bishopgate Street
Leeds
LS1 5DY
Tel No: 0113 243 5995

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Advantage Locations

LEICESTER

87A/89A Queens Road
Leicester
LE2 1TT

Tel No: 0116 270 7934

LIVERPOOL

Suite 677-679
6th Floor India Buildings
Water Street
Liverpool
L2 0RA

Tel No: 0151 227 9300

NEWBURY

2nd Floor
Bateman House
44 – 47 The Broadway
Thatcham
Berkshire
RG19 3HP

Tel No: 0845 638 2416

NORWICH

Rowan House
28 Queens Road
Hethersett
Norfolk
NR9 3DB
Tel No: 01603 813 969

NOTTINGHAM

Huntingdon House Bus. Centre
278 – 290 Huntingdon Street
Nottingham
NG1 3LY

Tel No: 0115 993 4282

PETERBOROUGH

Office 1&2
Thurston House
80 Lincoln Road
Peterborough
PE1 2SN
Tel No: 01733 763 033

PORTSMOUTH

44B West Street
Porchester
Hampshire
PO16 9UN
Tel No: 0239 238 2323

ROCHDALE

258 Milnrow Road
Rochdale
OL16 5BQ

Tel No: 01706 759 511

SHEFFIELD

14 Jessops Riverside
800 Brightside
Sheffield
S9 2RX
Tel No: 0114 244 9116

STRAND NURSING

Brettenham House
1 Lancaster Place
London
WC2E 7RN
Tel No: 0207 836 6396

TEES VALLEY

Dunedin House
Riverside Entrance
Columbia Drive
Stockton on Tees
TS17 6BJ
Tel No: 01642 626 340

WAKEFIELD

St Johns Business Centre
18 – 20 St Johns North
Wakefield
West Yorkshire
WF1 3QA
Tel No: 01924 371 000

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