

### Occupational Therapy

Please indicate the degree of experience you have had in each of these areas, by ticking in the appropriate column, where:

- 0 = No experience  
 1 = Limited - needing practice  
 2 = Moderate - but needing supervision  
 3 = Experienced - can work autonomously  
 4 = Teaching/Management - have led team; able to supervise/teach

	0	1	2	3	4		0	1	2	3	4
Orthopaedics - Elective	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatry - Acute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthopaedics - Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatry - Forensic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgical Wards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatry - Adolescent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Wards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elderly Mentally Ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elderly Care - Acute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amputees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elderly Care - Long Stay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H.I.V.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paediatrics (ages: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oncology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Young Disabled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CVA and Head Injury (Acute Rehab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Injuries (Acute Rehab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burns/Plastics/Splinting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheelchair Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vocational Rehab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others (please state): _____						Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please tick if you are trained in/hold certificates in the following:

Bobath  Carr and Shepherd  Other  Please Specify \_\_\_\_\_

If you have held responsibility for students or junior members of staff, please:

Explain type of supervision \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list clinical areas or specialities in which you would prefer to work:

1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

### Declaration

All the information contained in this application is true to the best of my knowledge and belief.  
 I have read and agree to the Terms and Conditions of Assignment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

# Physiotherapy

Please indicate the degree of experience you have had in each of these areas, by ticking in the appropriate column, where:

- 0 = New Graduate
- 1 = Junior Rotation (2 - 3 months)
- 2 = Senior II Rotation (6 - 12 months)
- 3 = Ongoing placement (1+ years)
- 4 = All of the above plus management experience

	0	1	2	3	4		0	1	2	3	4
Out-patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical Wards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Wards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthopaedics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I.T.U.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burns and Plastics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community - Adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community - Paeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paediatrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oncology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elderly Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amputees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Woman's Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others (please state):	_____										

Have you trained in/hold certificates in the following:

Bobath	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Carr and Shepherd	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Maitlands	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Hydrotherapy	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
McKenzie	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Cyriax	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

Please tick if you have:

Worked single-handedly	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Held responsibility for students or junior members of staff	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

Please list clinical areas or specialities in which you would prefer to work:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## Declaration

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Signed \_\_\_\_\_ Date \_\_\_\_\_

### Podiatry

Please indicate the degree of experience you have had in each of these areas, by ticking in the appropriate column, where:

- 0 = No experience
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- 3 = Experienced - can work autonomously
- 4 = Teaching/Management - have led team; able to supervise/teach

	0	1	2	3	4		0	1	2	3	4
Hospital Out-patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sports Events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital Wards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Centres	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domiciliary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Risk Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobile Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elderly Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transport Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Biomechanics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing Homes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paediatrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GP Practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private Practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Clubs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Health Promotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Have you training in:

Cardio-pulmonary Resuscitation (CPR)                      yes                       no

Treatment of Anaphylactic Shock                      yes                       no

### Please list clinical areas or specialities in which you would prefer:

<p>To work:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>	<p>Not to work:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>
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### Declaration

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I have read and agree to the Terms and Conditions of Assignment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

# Speech & Language Therapy

Please indicate the degree of experience you have had in each of these areas, by ticking in the appropriate column, where:

- 0 = No experience
- 1 = Limited - needing practice
- 2 = Moderate - but needing supervision
- 3 = Experienced - can work autonomously
- 4 = Teaching/Management - have lead team; able to supervise/teach

## Paediatrics

	0	1	2	3	4
Acute (General hospital based)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dysphagia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rehab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schools - Mainstream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schools - Special Needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Clinics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment Experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sign Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Makaton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moderate Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Profound & Multiple Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dysfluency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Voice Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Adults

	0	1	2	3	4
Acute (General Hospital Based)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dysphagia Trained	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dysphagia Experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Videoflouroscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rehab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dysphasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laryngectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Voice Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moderate Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AAC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dysfluency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Community</b>					
Home visits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have held responsibility for students or junior members of staff, please explain type of supervision:

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Please list clinical areas or specialities in which you would prefer to work:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

## Declaration

All the information contained in this application is true to the best of my knowledge and belief. I have read and agree to the Terms and Conditions of Assignment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

### Radiography

Please indicate the degree of experience you have had in each of these areas, by ticking the appropriate column, where:

- |  |   |
|--|---|
| 0 = No experience  | 1 = Limited - needing practice          |
| 2 = Moderate - but needing supervision                           | 3 = Experienced - can work autonomously |
| 4 = Teaching/Management - have led team; able to supervise/teach |   |

	0	1	2	3	4		0	1	2	3	4
Radiotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PACS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nuclear Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MRI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic: X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A+E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Theatre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sonography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthopaedics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lithotripsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paediatrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digital Fluoroscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digital Vascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spectroscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiographer performed enemas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angiography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						IV Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interventional procedures (please specify) _____							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please state any other area of experience: _____											

### Which machines do you have experience with?

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### Please state any reporting experience in ultrasound, A+E...:

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### If you have held responsibility for students or junior members of staff, please explain type of supervision:

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### Please list clinical areas or specialities in which you would prefer to work:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### Declaration

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Signed \_\_\_\_\_ Date \_\_\_\_\_

# Phlebotomy

Please indicate the degree of experience you have had in each of these areas, by ticking the appropriate column, where:

- |  |   |
|--|---|
| 0 = No experience  | 1 = Limited - needing practice          |
| 2 = Moderate - but needing supervision                           | 3 = Experienced - can work autonomously |
| 4 = Teaching/Management - have led team; able to supervise/teach |   |

## Patient contact

Establishing patient identity and consent

0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explaining procedure to patients

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Ascertaining if a patient has clotting

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Disorder/is on anticoagulants

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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## Taking the sample

Cleaning of venepuncture site

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Use of tourniquet

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Taking blood from butterfly/venflon

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Identifying/anchoring vein

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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## Handling samples

Verifying test required from request form

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Identifying correct sample bottle

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Labelling samples

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Knowledge of appropriate specimen transportation

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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## Safe practice

Understanding of universal precautions

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Safe handling and disposal of sharps

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Disposal of sharp bins

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Procedures to be followed following needlestick injury

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Please list clinical areas or specialities in which you would prefer to work:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please give details of your experience:

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Where did you obtain your Certificate of Competence?

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## Declaration

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Signed \_\_\_\_\_ Date \_\_\_\_\_

# Clinical Skills

Cardiac & ECG Technicians / MLSO's & MLAs



## Cardiac & ECG Technicians

Please indicate the degree of experience you have had in each of these areas, by ticking in the appropriate column, where:

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### Non-invasive

	0	1	2	3	4
ECGs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24 Hour Tape Analysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Tests & Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Echocardiography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	0	1	2	3	4
Doppler	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Holter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Invasive</b>					
Catheters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angiography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemakers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please give details of your Echo and catheter experience:

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What machines do you have experience with?

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Please list clinical areas or specialities in which you would prefer to work:

- \_\_\_\_\_
- \_\_\_\_\_

## Clinical Skills

If you have in-house training, please state where: \_\_\_\_\_

If not qualified, please state approximate numbers of ECGs done: \_\_\_\_\_

Do you have an ASCT Certificate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you worked independently?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you confident placing leads?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you confident reading and recording ECG findings?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you trained in doing 24 hour tapes and analysis ?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Which machines have you had experience with?	Siemens <input type="checkbox"/>	Marquette <input type="checkbox"/>
Other? (Please specify) _____		Hewlett Packard <input type="checkbox"/>

## Declaration

All the information contained in this application is true to the best of my knowledge and belief.  
I have read and agree to the Terms and Conditions of Assignment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

## MSLO's & MLA's

Please indicate the degree of experience you have had in each of these areas, by ticking in the appropriate column, where:

- 0 = None  
 1 = Theoretical knowledge  
 2 = Practical competence/experience during research  
 3 = One or more years in a routine lab  
 4 = Able to supervise

	0	1	2	3	4		0	1	2	3	4
Microbiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immunology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Virology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Haematology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Histology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coagulation Studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cytology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gynae Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Chemistry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phlebotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radio Immuno Assay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Public Health Lab Experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Instrumentation and computers you are familiar with, e.g. Cobas Mira Plus:

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Any other specific techniques, e.g. cutting (Histology):

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Microbiology Staff - Have you had a recent Mantoux Test?:

Result \_\_\_\_\_

### Declaration

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Signed \_\_\_\_\_ Date \_\_\_\_\_

### Orthopaedic Technicians

Please indicate the degree of experience you have had in each of these areas by entering the appropriate number in the box:

- 0 = No experience
- 1 = Limited - Needing practice
- 2 = Moderate - but needing supervision
- 3 = Experienced - can work autonomously
- 4 = Teaching/Management - have led team; able to supervise/teach

	Plaster of Paris	Alternative material	(Please specify)
Trimming	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drying	<input type="checkbox"/>	<input type="checkbox"/>	_____
Windowing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bi-Valving	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cast Removal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Negative Casting	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Specific Casts

Appropriate use of materials including Plaster of Paris and alternative casting materials. Positions, extent of cast and basic technique of:

		P/O/P	ALT		P/O/P	ALT
Slabs:	Below elbow	<input type="checkbox"/>	<input type="checkbox"/>	Above elbow	<input type="checkbox"/>	<input type="checkbox"/>
	Knee	<input type="checkbox"/>	<input type="checkbox"/>	Below knee	<input type="checkbox"/>	<input type="checkbox"/>
	'U' Slab	<input type="checkbox"/>	<input type="checkbox"/>			
Casts:	Colles'	<input type="checkbox"/>	<input type="checkbox"/>	Leg cylinder	<input type="checkbox"/>	<input type="checkbox"/>
	Scaphoid	<input type="checkbox"/>	<input type="checkbox"/>	Above knee	<input type="checkbox"/>	<input type="checkbox"/>
	Bennett's type	<input type="checkbox"/>	<input type="checkbox"/>	Hip spica	<input type="checkbox"/>	<input type="checkbox"/>
	Arm cylinder	<input type="checkbox"/>	<input type="checkbox"/>	Frog type	<input type="checkbox"/>	<input type="checkbox"/>
	Above elbow	<input type="checkbox"/>	<input type="checkbox"/>	Broomstick	<input type="checkbox"/>	<input type="checkbox"/>
	Shoulder spica	<input type="checkbox"/>	<input type="checkbox"/>	Corset/jacket	<input type="checkbox"/>	<input type="checkbox"/>
	Below knee	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis jacket	<input type="checkbox"/>	<input type="checkbox"/>
	Casts for clubfoot	<input type="checkbox"/>	<input type="checkbox"/>	Minerva jacket	<input type="checkbox"/>	<input type="checkbox"/>
	Bootees/slipper	<input type="checkbox"/>	<input type="checkbox"/>	Sarmiento type	<input type="checkbox"/>	<input type="checkbox"/>
	Walking attachments for leg casts	<input type="checkbox"/>	<input type="checkbox"/>			
	Functional bracing:	Humerus	<input type="checkbox"/>	<input type="checkbox"/>	Femur	<input type="checkbox"/>
Tibia		<input type="checkbox"/>	<input type="checkbox"/>			

**If you have held responsibility for students or junior members of staff, please explain type of supervision:**

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**Please list clinical areas or specialities in which you would prefer to work:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Declaration**

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Signed \_\_\_\_\_ Date \_\_\_\_\_

**ODP**

**Please indicate the degree of experience you have had in each of these areas by entering the appropriate number in the box:**

- 0 = No experience  
1 = Needing practice  
2 = Moderate - but needing supervision  
3 = Experienced - can work autonomously  
4 = Teaching/Management - have lead team; able to supervise/teach

	Anaesthetics	Scrub	Recovery
General Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiothoracic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transplants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burns/Plastics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthopaedics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maxillo-Facial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ophthalmics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**In which clinical areas or specialities do you prefer to work:**

1. \_\_\_\_\_

2. \_\_\_\_\_

**Declaration**

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I have read and agreed to the Terms and Conditions of Assignment.

Signed \_\_\_\_\_ Date \_\_\_\_\_