

Please bring the following items, and the completed list with you to interview, using the tick boxes to check off the items.

Documents Required	Tick
A completed Nurse application form (<i>filled in completely with no gaps in work history</i>).	
A completed Declaration of Health questionnaire and written confirmation of all immunisations if available. We would encourage you to bring appropriate documentation, i.e. GP Card to prove all immunisations.	
Names and contact details for two professional references covering at least the past year. <i>NB. One must be from your current or most recent employer. References can only be sent to establishment addresses.</i>	
2 passport photographs (<i>recent and matching, signed and dated on the back</i>).	
3 forms of ID and proof of address . Please see the enclosed guide on acceptable forms of ID.	
One of the following original documents showing your National Insurance number: <ul style="list-style-type: none"> • A payslip from your previous employer • Your P60 • A letter from a government agency • A P45 	
Your P45, if applicable.	
Your NMC PIN Card	
Confirmation of Professional Indemnity Insurance e.g. UNISON / RCN Card.	
Original certificate (preferable) or copies of any course or qualification you have completed during your professional career.	
Copies of any relevant training certificates completed within the past year (<i>if you are unable to provide evidence of any of the training below, we can arrange it</i>) <ul style="list-style-type: none"> • Manual Handling (evidence of a practical course) • Infection Control (including MRSA and C Diff) • Abuse Awareness (POCA and POVA) • Health and Safety (inc. COSHH and RIDDOR) • Basic Life Support (Practical) • Basic Food Hygiene • Fire Safety • Medication Training 	
Driving licence (<i>photo card and counterpart</i>), MOT & business insurance, if your role involves you using your car in the course of your duties.	
A cheque for £36.00 for your CRB Disclosure made out to Advantage Healthcare Group Limited (<i>This can be reclaimed via our FOR LIFE reward scheme once you are working</i>).	
Your bank account details (<i>if you do not have one we can help you set one up</i>).	
Overseas Workers A police check valid within the previous 3 months for overseas applicants who have entered the UK within the last 6 months.	

Neurological

Skill	I	II	III
Care of head injury patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient during/post seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient post craniotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient post neck/back surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient post spinal cord injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform neurological observations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of glasgow coma scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Orthopaedics

Skill	I	II	III
Application of POP casts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient post hip replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient post joint reconstructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient post total knee replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient using CPM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal

Skill	I	II	III
Abdominal assessment eg. for bowel sounds etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of enemas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of NG feeds - bolus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- via pump eg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of suppositories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of abdominal drains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of colostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of ileostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient post gastrointestinal surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient with hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient with inflammatory bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of percutaneous endoscopic gastrostomy (PEG) tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of T-tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Check placement of NGT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flexiflo systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insertion of naso-gastric tube (NGT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Renal

Skill	I	II	III
Care of an AV fistula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of a patient post nephrectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of a patient post renal transplant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of nephrostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient with renal failure - chronic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- acute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insertion of urinary catheter - male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- short term/intermittent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage peritoneal dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage venous dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform bladder irrigation - continuous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- intermittent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform urinalysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Endocrine/Metabolism

Skill	I	II	III
Blood sugar level testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of a total parental nutrition infusion/lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient post a drug overdose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient with diabetes insipidus/ disorders of the pituitary gland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient with thyroid disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorders of the adrenal gland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Management of a sliding scale of insulin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Management of insulin dependent diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Management of IV insulin infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Management of non-insulin dependent diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Infection control

Skill	I	II	III
Assessment and care of pressure sores/ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burn care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of surgical drains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of the isolated patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge of universal precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wound care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wound packing/ irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

General

Skill	I	II	III
Syringe Drives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administering Subcutaneous infusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6 General information

Do you hold a current driving licence? YES <input type="checkbox"/> NO <input type="checkbox"/>	Do you have a current passport? YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you have a car available? YES <input type="checkbox"/> NO <input type="checkbox"/>	Typing/WP experience? YES <input type="checkbox"/> NO <input type="checkbox"/>
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? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Body name	Amount of cover
Policy number	Expiry date

7 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 <input type="checkbox"/>	full-time <input type="checkbox"/>		
Type of work	NHS <input type="checkbox"/>	private hospitals <input type="checkbox"/>	nursing home <input type="checkbox"/>	industry <input type="checkbox"/>
	Clients in their own home <input type="checkbox"/>	Other, please specify _____		
	live-in <input type="checkbox"/>	days <input type="checkbox"/>	nights <input type="checkbox"/>	visits <input type="checkbox"/>
Do you have any other work commitments?	YES <input type="checkbox"/>	NO <input type="checkbox"/>		
Which areas of work do you wish to exclude?				
When will you be available to start work?				
Length of time available? (for overseas nurses only)				

8 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: _____

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

Care Standards Act 2000: 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/Disclosure Scotland check which will be required if your application is successful)

9 Permanent posts in the UK and placement overseas

Are you interested, now or in the future, in permanent posts in

UK	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Overseas	YES <input type="checkbox"/>	NO <input type="checkbox"/>

10 References

Please give the names of referees, to whom you have reported, including your present or most recent employer, whom we may approach for a reference. A minimum of three years history must be covered. (Business address to be given).*

**Referees must be a previous/current supervisor/manager/employer.*

Can we contact your referees before your interview?

1. YES <input type="checkbox"/>	NO <input type="checkbox"/>	2. YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. YES <input type="checkbox"/>	NO <input type="checkbox"/>	4. YES <input type="checkbox"/>	NO <input type="checkbox"/>

1st Referee	Name	Position
Address		
		Email
Post code	Telephone number	Known me for _____ years
2nd Referee	Name	Position
Address		
		Email
Post code	Telephone number	Known me for _____ years
3rd Referee	Name	Position
Address		
		Email
Post code	Telephone number	Known me for _____ years
4th Referee	Name	Position
Address		
		Email
Post code	Telephone number	Known me for _____ years

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 MANAGER.

Failure to observe these rules will be regarded as serious misconduct which could result in removal from the agency register.

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 nurses 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

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 work. I understand that knowingly giving false information will disqualify me from registration with this agency.

Signed					Date					
Name					Position applied for				Location	

Advantage Healthcare Group Ltd aims to be an equal opportunities work provider 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"/> please specify	Other	<input type="checkbox"/> please specify	Pakistani	<input type="checkbox"/>

Acceptable forms of Identification

Which documents do you need to provide?	
Can you produce any documents from Group 1?	
Yes	No
3 Documents must be seen. One document from Group 1 plus any two from Groups 1 or 2	5 documents must be seen Five documents from Group 2

Please note, all documents must be in your current name (marriage certificate excepted). At least one document must show your current address and at least one document must show your date of birth.

Group 1	
Passport	Any nationality
UK birth certificate	Issued within 12 months of date of birth – full or short form acceptable including those issued by UK authorities overseas, such as embassies, High Commissions and HM Forces.
UK Driving Licence	England / Scotland/ Northern Ireland / Isle of Man: either photo card or paper. A photo card is only valid if presented with the counterpart licence.
EU National Identity Card	EU countries only
HM Forces ID Card	(UK)
UK Firearms Licence	
Adoption Certificate	(UK)
Group 2	
Marriage / Civil partnership certificate	
Financial Statement	Eg pension, endowment, ISA issued within the last 12 months.
Birth Certificate	
Vehicle Registration Document	Document V5 old style and V5C new style only
P45 / P60 Statement (UK)	Issued within the last 12 months.
Mail Order Catalogue Statement	Within the last 3 months
Bank / Building Society Statement	Within the last 3 months
Court Claim Form (UK)	Document issued by Court Services
Utility Bill	Electricity, gas, water, telephone – inc. mobile phone contract / bill. Must be issues within the last 12 months.
TV licence	Must be issued within the last 12 months.
Addressed payslip	No more than 3 months old.
Credit Card Statement	No more than 3 months old.
National Insurance Card	(UK)
Store Card Statement	No more than 3 months old
NHS Card	(UK)
Mortgage statement	Issued within the last 12 months
Benefit Statement	i.e. Child Allowance, Pension. No more than 3 months old.
Insurance Certificate	Issued within the last 12 months
Certificate of British Nationality	(UK)
Council Tax Statement	(UK) Issued within the last 12 months.
Visa	(UK) Issued within the last 12 months.
A document from Central / local government / Government Agency / Local Authority giving entitlement (UK)	eg. Department for Work and Pensions, the employment Services, Customs and Revenue, Job Centre, Job Centre Plus and Social Security.
Connections Card	UK
CRB Disclosure Certificate.	Issued within the last 12 months.

Declaration of Health

Please complete both sides of this form carefully, writing clearly. Failure to give full details could cause delay in processing your application/continuing work. Please attach a separate sheet of paper if necessary.

1 Personal Details

Title	Surname	Forename(s)
Date of birth	Branch	
UK Address		
Post code	Telephone number	Mobile
GP name	GP Telephone number	
GP address		

2 Declaration of Health

Immunisations

Rubella	YES <input type="checkbox"/>	Date ____/____/____	NO <input type="checkbox"/>	Hepatitis B Injections	1st <input type="checkbox"/>	Date ____/____/____	
BCG	YES <input type="checkbox"/>	Date ____/____/____	NO <input type="checkbox"/>	2nd <input type="checkbox"/>	Date ____/____/____	3rd <input type="checkbox"/>	Date ____/____/____
Skin Test for TB	YES <input type="checkbox"/>	Date ____/____/____	NO <input type="checkbox"/>	Booster	1st <input type="checkbox"/>	Date ____/____/____	
Tetanus	YES <input type="checkbox"/>	Date ____/____/____	NO <input type="checkbox"/>	2nd <input type="checkbox"/>	Date ____/____/____	3rd <input type="checkbox"/>	Date ____/____/____
Chickenpox	YES <input type="checkbox"/>	Date ____/____/____	NO <input type="checkbox"/>	Date of last blood test			
Poliomyelitis	YES <input type="checkbox"/>	Date ____/____/____	NO <input type="checkbox"/>	Titre Result			
Diphtheria	YES <input type="checkbox"/>	Date ____/____/____	NO <input type="checkbox"/>	Date			
Other <i>please specify</i> _____							
Have you had Chickenpox?				YES <input type="checkbox"/>	NO <input type="checkbox"/>		

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
On the next page 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	

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 (Latex allergy)	<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 Declaration

I declare that I am fit for work and that all information is correct and accurate to the best of my knowledge.

Signature _____	Name _____	Date _____
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For office use only

1. Fit without restrictions	<input type="checkbox"/>	3. Needs GP/specialist report	<input type="checkbox"/>
2. Fit with restrictions (see below)	<input type="checkbox"/>		

Restrictions/comments

1. Needs to clarify Hep B status	<input type="checkbox"/>	4. Latex allergy	<input type="checkbox"/>
2. Advise sees GP/Practice Nurse	<input type="checkbox"/>	5. Other allergies:	<input type="checkbox"/>
3. Needs to complete GP Authorisation Form (see HR Manual)	<input type="checkbox"/>	_____	

RGN Co-ordinator

Signature _____	Name _____	Date _____
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Need for Referral <input type="checkbox"/>	To whom _____	Date to review _____
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