Dolphins Medical

**NURSES, CARE ASSISTANTS, SUPPORT WORKERS**

| PERSONAL DETAILS | |
|---|---|
| Title: | First Name: |
| Middle Name: | Last Name: |
| Maiden Name: | Known as: |
| Date of birth: | Marital Status: |
| House Name/Number: | |
| Address: | |
| | City/Town: |
| County: | Post Code: |
| Home Phone: | Work Phone: |
| Qualification: | Position applied for: |
| NMC PIN NO. | |

| RIGHT TO WORK | |
|---|---|
| National Insurance Number: | |
| Passport (please tick) European Economic Area National ☐Foreign National ☐ | |
| Country of origin: | |
| Date of first entry in the UK | |
| UK Entry Clearance Visa/Residence Permit | Indefinite leave to remain☐ |
| Limited leave to remain-no remarks or observations ☐ | |
| Limited leave to remain-with remarks or observation☐ | |

| NEXT OF KIN | |
|---|---|
| Name: | Relationship: |
| Mailing Address | |
| | |
| Post Code | Telephone Number |

**EMPLOYMENT HISTORY**

**FILL IN FORM ☐ OR SUBMIT CURRICULUM VITAE ☐**

**USE CONTINUATION SHEET IF NECESSARY**

**Please give 10-year history of employment below, do not cross out and write 'see CV'. Gaps of more than 3 months must be accounted for. Use separate sheet if required.**

| | |
|---|---|
| From: / / To: / / | Employer: |
| Address: | |
| Phone Number: | Main Contact |
| Position: | Grade: |

Dolphins Medical

**NURSES, CARE ASSISTANTS, SUPPORT WORKERS**

| | |
|---|---|
| Full or part time: | Salary: |
| Dept/Ward: | Reason for leaving: |

## EMPLOYMENT HISTORY

| | | | | | |
|---|---|---|---|---|---|
| From: | / | / | To: | / | / | Employer: |
| Address: | | | | | |
| Phone Number: | | | | | Main Contact |
| Position: | | | | | Grade: |
| Full or part time: | | | | | Salary: |
| Dept/Ward: | | | | | Reason for leaving: |

## EMPLOYMENT HISTORY

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|---|---|---|---|---|---|
| From: | / | / | To: | / | / | Employer: |
| Address: | | | | | |
| Phone Number: | | | | | Main Contact |
| Position: | | | | | Grade: |
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| | | | | | |
|---|---|---|---|---|---|
| From: | / | / | To: | / | / | Employer: |
| Address: | | | | | |
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## EMPLOYMENT HISTORY

| | | | | | |
|---|---|---|---|---|---|
| From: | / | / | To: | / | / | Employer: |
| Address: | | | | | |
| Phone Number: | | | | | Main Contact |
| Position: | | | | | Grade: |
| Full or part time: | | | | | Salary: |
| Dept/Ward: | | | | | Reason for leaving: |

## EQUAL OPPORTUNITIES

**For the purpose of monitoring our Equal opportunities policy which is available on request, please complete the following**

Dolphins Medical

**NURSES, CARE ASSISTANTS, SUPPORT WORKERS**

| | |
|---|---|
| Age: | Gender: |
| Ethnic Origin: | Prefer not to say |

Do you consider yourself to have a disability under the Equality Act 2010? YES☐ NO☐

Prefer not to say ☐

| | |
|---|---|
| Religion/ Belief: | Prefer not to say ☐ |
| Sexual Orientation | Prefer not to say ☐ |

## PROFESSIONAL REFERENCES

**Please provide two professional references from your most recent employers, one of which must be your current employer.**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Name of Referee: | | | Company name: | | | | |
| Position: | Start date: | / / | | End date | / / | | To date ☐ |
| Mailing Address: | | | | | | | |
| Country: | | | Post Code: | | | | |
| Telephone: | | | Fax | | | | |
| Email: | | | Phone Number | | | | |

## PROFESSIONAL REFERENCES

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Name of Referee: | | | Company name: | | | | |
| Position: | Start date: | / / | | End date | / / | | To date ☐ |
| Mailing Address: | | | | | | | |
| Country: | | | Post Code: | | | | |
| Telephone: | | | Fax | | | | |
| Email: | | | Phone Number | | | | |

## PAYROLL DETAILS

| | |
|---|---|
| Bank Name: | Sort Code: |
| Account Number: | Account Name: |

I hereby authorise Dolphins Medical to pay my weekly earning into the bank whose details I have provided above. I will notify Dolphins Medical of any changes to my bank details.

Dolphins Medical

**NURSES, CARE ASSISTANTS, SUPPORT WORKERS**

| **Signed:** | **Date:** | **Print Name:** |
|---|---|---|

I hereby opt out of the 48 HOUR Working week agreement and consent that the working week limit shall not apply to my assignments. If I choose to end this agreement I will give 14 days' notice of Withdrawal of Consent in writing to Dolphins Medical

| **Signed:** | **Date:** | **Print Name:** |
|---|---|---|

**REHABILITATION OF OFFENDERS**

This post is exempt from the provisions of Section 4.2 of the Rehabilitation of Offenders Act 1974 (Exemption Order 1975) therefore you are required to provide information about convictions which are 'spent'. Failure to disclose such convictions can result in dismissal or disciplinary action. Any information provided will be treated with strictest confidence and will only be considered in relation to application for positions in which the order applies. Please note that a criminal record does not disadvantage the candidate.

DBS legislation changes which commenced on the 29 May 2013, certain specified old and minor offences issued from this date will be removed from criminal record certificates. In view of these changes, question e55 on their application for a criminal record check has been changed. When filling in the form the question "Have you ever been convicted of a criminal offence or received a caution, reprimand or warning? should be treated as "Do you have any unspent convictions, cautions, reprimands or warnings?"

**CANDIDATE DECLARATION**

I declare that all the information that I have provided to Dolphins Medical in this application form is true and complete to the best of my knowledge. I have read and understood the terms of engagement and I agree to abide by these terms whilst on assignment. I understand that Dolphins Medical will carry out extensive checks including occupational health assessments, criminal records check, employment eligible checks (ID scanner) and mandatory training prior to my commencing any assignments and to do annual updates. Acceptance onto the Dolphins Medical register will be subject to passing all credential checks to a satisfactory level.

Copies of the policies, procedures and handbook of the employment are available upon request. Dolphins Medical reserves the right to hold any information and any other data required to process this application, keep and allow access in accordance with the Data Protection Act. I hereby give permission for Dolphins Medical to allow minimum access to my file information only for audit or client compliance purposes, carried out by but not limited to CQC, any official regulatory body and the NHS Framework. I hereby give permission for the Dolphins Medical to access my DBS information via the DBS Update Service and I understand that this information will be shared in accordance with the Data Protection Act with other regulatory bodies for compliance and audit purposes.

**AGENCY WORKER HANDBOOK**

I confirm that I have read the agency handbook which details the goals, policies, benefits and expectations of Dolphins Medical and its clients as well as my responsibilities whilst on assignment. I acknowledge, understand, accept and agree to comply with the information contained within the handbook. Dolphins Medical will inform me when the handbook has been updated.

Dolphins Medical

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**PROFESSIONAL INDEMNITY**

I am aware that professional indemnity is a lawful and mandatory requirement according to the Nursing and Midwifery Code of Conduct. acknowledge that Dolphins Medical has advised me to have my own personal professional indemnity insurance due to the limits of indemnity available under the Clinical Negligence scheme for Trusts (CNST) which is insufficient to cover all the situations in which may arise. Failure to get a personal professional indemnity insurance may result in my liability for all costs in relation to claims made against me.

| **Signed:** | **Date:** | **Print Name:** |
|---|---|---|