



# Application Form



Photo

<b>Application for the post of:</b>	<b>Branch:</b>
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Title: Mr/Mrs/Miss/Ms/Dr/Other	Forenames:					
Surname:						
Address:						
Postcode:	Telephone:					
email:	Fax:					
	Mobile:					
	National Insurance Number: <table border="1"><tr><td></td><td></td><td></td><td></td><td></td></tr></table>					

<b>Next of Kin</b>	
Name:	Relationship:
Address:	
Postcode:	Telephone:
	Mobile:

<b>Professional / Vocational Qualifications</b>		
Name of Professional Body - GMC, UKCC/NMC, Professions Allied to Medicine etc.	Membership Grade and/or Registration Number and PIN	Date of Expiry

Please state where you heard of this vacancy. (newspaper, journal, friend etc.)

## Employment History

### Present Employer

Name and address of present (or most recent) employer and nature of business	Position held	From Month/Year	To Month/Year

Grade (If Applicable):

Period of Notice Required:

Length of Time in Post:

### Previous Employers (Full employment for the last 10 years, please use additional sheet if necessary)

Name of previous employers and nature	Position held	Type of ward/department	Dates	
			From	To

### Referees (These must be for your line manager)

Name:	Name:
Position:	Position:
Organisation:	Organisation:
Address:	Address:
Telephone:                      Fax:	Telephone:                      Fax:
Worked from:                      to:	Worked from:                      to:
When may we approach this referee?	When may we approach this referee?

## Additional Training/Qualifications

Name/address of Training Establishment(s)	Qualifications Obtained	Date

## Special Interests/ Additional Comments

Have you previously worked for another employment/nursing agency? Yes  No

If yes, please state name of organisation:

Date:

## Ethnic Origin

Choose **ONE** section, then tick the appropriate box to indicate your cultural background.

### White

#### British

- English
- Scottish
- Welsh
- Other, (please state):
- Irish
- Any other White background

(please state):

### Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background

(please state):

### Mixed

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed background

(please state):

### Black or Black British

- Caribbean
- African
- Any other Black background

(please state):

### Chinese or other ethnic group

- Chinese
- Any other

(please state):

Non EC Nationals	Transport
Do you <b>have</b> a Work Permit? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have a Driver's Licence? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you <b>need</b> a Work Permit? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you own your own transport? Yes <input type="checkbox"/> No <input type="checkbox"/>

Is your partner, any member of your family or household employed by this company?

Yes  No

If Yes who?

Name:

Job Title: Place of Work:

**Rehabilitation of Offenders Act 1974**

By virtue of the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975, the provisions of Section 4.2 of the Rehabilitation of Offenders Act 1974 do not apply to any employment which is concerned with the provision of health services and which is of such kind as to enable the holder to have access to persons in receipt of such services in the course of his normal duties. Your answer to the following question should include any 'spent' convictions.

Have you ever been convicted of a criminal offence? Yes  No

If Yes, please give details:

**Declaration**

1) I affirm that the information set out in this form is true and correct, is not misleading and that no material information has been omitted. I understand and agree that if I submit any false or misleading information or omit any material information this may result in an offer of employment being withdrawn or, if I have already been employed, in my dismissal.

2) I understand and agree that I have read the conditions of Better Healthcare Services and agree to be bound and comply with the same.

3) I confirm that under the Data Protection Act 1998, I give my full consent for Better Healthcare Services to verify all the information given on this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_