



HARRIET ELLIS
medical recruitment ltd

APPLICATION FORM

Your Personal Details:	
Mr/Mrs/Ms/Dr	Forename:
Surname:	Male/Female:
Date of Birth:	Home Tel:
Work Tel:	Mobile Tel:
Pager/Bleep:	Fax No:
Address:	
Post Code:	E: Mail:
Nationality:	Country of Origin:
Next of Kin: (In case of Emergency)	Tel No:
What type of Working Visa do you hold?	Expiry Date:

Your Requirements	
<i>To help us find the most appropriate work for you please answer the following questions.</i>	
Profession:	Speciality:
What type of work are you looking for:	<i>Please Circle</i> Full Time Part Time Permanent
What Location would you prefer to work in:	1st Choice: 2nd Choice: 3rd Choice:
Would you be prepared to live in Hospital Accommodation?	
Do you have a current driving licence or International licence:	
When are you available to start work?	
How did you hear of us?	<i>Please Circle</i> Internet Advert Recommendation Other

Your Professional Qualifications:			
Institution	Qualifications	Date Commenced	Date Qualified

Please state what professional body you are belong to: i.e. HPC/GMC/UKCC

Registration Number:

Expiry Date:

Please enclose copies of your relevant qualifications with your application.

Work History				
Employer	Dates	Grade	Pay Rate	Post

If you do not have a CV and require more space, please attach additional sheet to the back of this form.

Medical Questionnaire			
How many sick days have you had in the last 12 months? Please give reasons and duration.			
Most Recent Chest X Ray			
Date	Result		
1)			
2)			
Do you currently smoke		Yes	No
If yes how many do you smoke a day		Less than 5	Between 5 -20 Over 20
Do you drink Alcohol?		Yes	No
If yes,, what amount daily			
What is your height?			
What is your weight?		St	lb

Do you currently, or have you in the past suffered from any disorders relating to the following symptoms?		
Respiratory (including asthma, pneumonia, breathlessness or allergies	Yes	No
Cardiovascular (including high blood pressure or chest pains	Yes	No
Gastrointestinal (including dysentery, typhoid or any gastric ailment	Yes	No
Central Nervous (including Headaches, migraine, fits or epilepsy	Yes	No
Genito Urinary (including any kidney or bladder infections)	Yes	No
Dermatological (including eczema, dermatitis or any skin infections)	Yes	No
Endocrinology (including diabetes, thyroid or gland disorder	Yes	No
Haematological (including low red blood cell count)	Yes	No
Locomotors (including rheumatoid arthritis, prolonged backache, disc trouble	Yes	No
Have you any known allergies	Yes	No
Have you ever taken an overdose of drugs?	Yes	No
Do you have a history of mental illness?	Yes	No
Do you have a medical condition affecting sleep?	Yes	No
Is there any medical reason why you could not work at night	Yes	No
Are you pregnant	Yes	No
Have you ever been treated for abuse or addiction to any substances	Yes	No
Are you currently under medical supervision or taking any medication	Yes	No

If yes please give details below:

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Your Vaccination Record

What following vaccinations have you had in the past 10 years

	Yes	No	Date
Hepatitis B			
Tuberculosis (BCG)			
Positive Heaf Test			
Tetanus			
Rubella Screening Test			
Oral Polio			
Typhoid			
Diphtheria			
Chicken Pox			

Please provide documentary evidence (a copy of original certification) or a letter from your GP together with this application form

Hospitals in the UK may not employ healthcare workers unless they are able to produce documentary evidence of Hepatitis B status.

Please sign and confirm that the information you have supplied is correct and you will notify Harriet Ellis Medical Recruitment Ltd of any relevant changes.

Print Name

Signature

Date

Continued Professional Development Training

Please list below details of any relevant courses completed (please enclose copy certificates)

Courses Name	Location	Date

Training Details

Health and Details

Have you completed an approved lifting/manual handling programme	Yes	No
Have you completed a course in Basic Cardiopulmonary Resuscitation	Yes	No
Have you completed a course in control and Restraint Techniques	Yes	No

Your Referees

Harriet Ellis Medical Recruitment Ltd will only contact your referees once we have your permission

Please give the names and addresses of your referees. One referee should be your current or last employer.

Name:

Address:

Tel:

Fax:

Email:

Name:

Address:

Tel:

Fax:

Email:

Professional Conduct

Rehabilitation of Offenders Act 1974

Virtually all the assignments we arrange are with clients who are exempt from the provision of section 4(2) of the Rehabilitation of Offenders Act 1974. Applicants are therefore not entitled to withhold information about any convictions which for other purposes are “spent” under the provision of the Act. Any information given will be completely confidential and will be considered in relation to an application for the positions to which the order applies. Please sign below if you have no such declarations to declare. (If not, please contact us for advice)

Signed **Date**

Police Checks (UK based applicants)

In positions where you will have substantial access to children, the sick or vulnerable you will be required to have a British Police Criminal Record check, which will identify all past conviction, including those passed as spent. Please note that many employers now require a police check for all health care professionals.

Have you had a Police check in the past 3 years Yes No

Police checks (Non UK based applicants)

If you are from outside the UK, please make sure that you apply for a Police check in your home country before travelling to the UK.

Professional Misconduct

Have you ever been the subject of professional misconduct proceedings or suspensions from an employer, or such pending or threatened against you either in the UK or abroad.

Yes No

If yes please give details attached to this application.

48-Hour Working Week Opt-Out

The Working Time Directive states that staff cannot be forced to work more than an average of 48 hours per week. You are free to accept as many or as little hours as you wish. In case you should wish to work more than 48 hours per week then please sign below.

Signed **Print Name**

Aids/HIV infected healthcare workers

I confirm that I am aware of the department of Health’s guidelines on Aids /HIV infected healthcare workers issued in April 1993 and agree to abide by these recommendations.

Signed **Print Name**.....