

Please complete this accurately, giving as many details as possible. Short listing will be based on the information gathered from the form, read in conjunction with the job description.

Position Applied for:			Yes	No
<b>Job Title:</b>		<b>Work Availability:</b> The information provided will enable us to match you with the needs of our clients and may affect the type/ location of position you are considered for.	<b>I am able to work Days</b>	
<b>Job Location:</b>			<b>I am able to work Nights</b>	
<b>Reference Number of advert/role:</b>			<b>I am able to work Weekends</b>	
<b>Where did you see post advertised?</b>				
			<b>I cannot start before</b>	
			<b>I cannot work later than</b>	

(MR/MISS/MRS/MS)	FORENAME	SURNAME				
PREVIOUS SURNAME	NATIONALITY					
DATE OF MARRIAGE (IF APPLICABLE)						
CURRENT FULL ADDRESS <sup>1</sup>	PREVIOUS ADDRESS <sup>2</sup> (IF YOU HAVE LIVED AT CURRENT ADDRESS LESS THAN 5 YEARS)					
POSTCODE <sup>1</sup> :	POSTCODE <sup>2</sup>					
DATE OF BIRTH						
HOME TELEPHONE NUMBER	MOBILE NUMBER					
EMAIL ADDRESS	NATIONAL INSURANCE NUMBER:					
DO YOU HOLD A FULL & CURRENT UK DRIVING LICENSE Yes <input type="checkbox"/> No <input type="checkbox"/>	DO YOU HAVE DAILY USE OF A CAR? Yes <input type="checkbox"/> No <input type="checkbox"/>					
DRIVING LICENSE NUMBER	PASSPORT NUMBER					
<b>NEXT OF KIN (TO BE NOTIFIED IN CASE OF EMERGENCY)</b>						
FULL NAME	RELATIONSHIP					
FULL ADDRESS						
		POSTCODE				
HOME TELEPHONE NUMBER	MOBILE NUMBER					
WORK AREA PREFERENCES (NHS, NURSING HOMES, Supported Living, Homecare, MH, LD, Care of Older People, Chal Behaviour, ETC):						
DATE AVAILABLE TO COMMENCE	GEOGRAPHICAL AREAS YOU WOULD LIKE TO WORK:					
DO YOU SPEAK ANY OTHER LANGUAGE AS WELL AS ENGLISH? YES NO						
LANGUAGE	WRITTEN			SPOKEN		
	FLUENT	GOOD	FAIR	FLUENT	GOOD	FAIR
<b>English</b>						

**EMPLOYMENT HISTORY**

GIVE DETAILS OF YOUR COMPLETE EMPLOYMENT HISTORY FROM THE DATE YOU LEFT FULL TIME EDUCATION WITHOUT GAPS IN DATES. INCLUDE REASONS FOR ANY GAPS IN EMPLOYMENT. CONTINUE ON A SEPARATE SHEET IF NEEDED.

NAME & ADDRESS OF EMPLOYER	POSITION	FROM	TO	GRADE	REASON FOR LEAVING

**EXPERIENCE QUESTIONNAIRE** *To enable us to assess your experience, please TICK the appropriate boxes*

Experience working in Hospitals i.e. HDU, Renal, Oncology	<input type="checkbox"/>	Nursing/Residential Homes	<input type="checkbox"/>
Experience working in E.M.I Units	<input type="checkbox"/>	Experience of caring for those with physical disabilities	<input type="checkbox"/>
Experience working in learning disabilities services	<input type="checkbox"/>	Experience of spinal injury care	<input type="checkbox"/>
Experience working in Mental Health services	<input type="checkbox"/>	Experience of acquired brain injury care	<input type="checkbox"/>
Experience working in children's residential homes	<input type="checkbox"/>	Experience of stroke patient care	<input type="checkbox"/>
Experience of caring for the terminally ill	<input type="checkbox"/>	Experience of caring for people with degenerative conditions	<input type="checkbox"/>
Experience working in youth offending services	<input type="checkbox"/>	Experience of taking and recording general observations	<input type="checkbox"/>
Experience working with children with learning disabilities	<input type="checkbox"/>	- Please state i.e. Blood Pressure, Pulse, Fluid Balance, Temperature	<input type="checkbox"/>
Experience with drug/alcohol problems	<input type="checkbox"/>	Experience with Children/Families	<input type="checkbox"/>
Clinic or community based practice	<input type="checkbox"/>	Experience of HIV/Aids Care	<input type="checkbox"/>

**Any Others, Please State**

**QUALIFICATIONS AND REGISTRATION**

Union Membership (RCN, Unison etc)	Membership No & Expiry Date:
NISCC PIN	Renewal Date:
Please provide details of your further Education/Training	
Name of Establishment	Qualifications Gained
Date of Attendance	From: _____ To: _____
Due to new Agency Worker Regulations, we are required to ask if you work for or are registered with any other Agency. Please state name of Agency:	
Signature: _____	Date: _____



## TRAINING

Please provide the dates that you last undertook the following training courses and provide copies of certificates at interview.

Training Course	Date of Last Training	Training Course	Date of Last Training
Moving & Handling		Administration of Medication	
Fire Safety		Protection of Vulnerable Adults	
Health & Safety (1974/1999 Acts including COSSH/RIDDOR)		Food Hygiene	
Infection Control		Physical Intervention and De-escalation (C&R)	
Venepuncture		Child Protection	
Emergenices in First Aid & CPR		Mental Health / Dementia	
Student Nurse/NVQ/QCF		Certificates Provided for Training YES <input type="checkbox"/> NO <input type="checkbox"/> Signed	

Please give details of any further training, for which, certificates must be provided at interview:

## WORKING TIME DIRECTIVE

The European Union has laid down guidelines for all workers, governing the length of the maximum working week that it is safe to work. The current limit is 48 hours per week. As you are under no obligation to accept work offered, you will never be compelled to work more than 48 hours per week but you may choose to do so. Please would you sign below to confirm that you have read and understood this information and please indicate your preferences by **ticking the most appropriate box**.

I **DO NOT** wish to work more than 48 hours per week

I **DO** wish to work more than 48 hours per week

Signature:

Date:

## ABUSE POLICY

I understand that I must be aware of the prevention of abuse policies that are enforced by the Department of Health and Social Care in any placement that I may work. I have been advised that Platinum will retain a copy of these policies and I can access them at any time.

Signature:

Date:

## DATA PROTECTION ACT 1998 & INSPECTION

We are required to hold personal information on staff e.g. National Insurance Number, Address, Qualifications. From time to time we may be required to release elements of this information when placing you in assignments; please be assured that we would only disclose information that is necessary. We would therefore be grateful if you would complete and sign the declaration below. If you have any concerns about this or want to discuss it further, please contact your branch manager.

**I consent to the disclosure of information required to place me on assignments.**

Print Name:

Signature:

Date:

## DECLARATION INVESTIGATION/SUSPENSION

Are you currently suspended from duty with another organisation? YES  NO

If 'YES' please provide details and the current investigation status on a separate sheet.

I agree to inform Platinum if, at any time, whilst registered with them, I am suspended from duty by another organisation. Signature:

Date:

## DECLARATION

The information I have given in this registration form is, to the best of my knowledge, complete and accurate in all aspects. I understand that knowingly giving false information will disqualify me from registration with this agency. I also agree to keep Platinum advised of any updates to this information supplied.

Signature:

Print Name:

Date:

## HEALTH DECLARATION (if you have suffered from any of these in the past, please provide details)

	State 'YES' or 'NO'	If yes, please give further details	
Have you ever had to leave employment for health reasons?			
Do you suffer from black outs, fits, giddiness or have any condition of vision/hearing which may affect your ability to work?			
Do you suffer from cardiovascular symptoms, chest pains, irregular blood pressure, varicose veins, haematological disorders or diseases, asthma, bronchitis or tuberculosis?			
Do you suffer from stress, depression, mental illness or nervous breakdown, alcoholism or drug related symptoms?			
Do you suffer from gastrointestinal, bowel, typhoid, paratyphoid or dysentery problems?			
Do you suffer from Immuno-deficiency symptoms e.g. HIV Positive, disease or disorder?			
Do you suffer from any bladder or kidney disorders?			
Do you suffer from dermatitis, skin conditions, allergy to latex gloves or powder?			
Do you suffer from back problems, or rheumatism or arthritis?			
Do you suffer from diabetes, thyroid, or other gland problems?			
Do you suffer from recurrent sore throats or have you been treated for MRSA infections?			
Have you ever had mumps, measles, shingles or chicken pox?			
Have you any reason to believe you have been infected by any communicable disease? Eg Scabies, lice, measles, chicken pox,			
Are you pregnant?			
Do you have any allergies?			
Do you smoke?		If Yes, how many per day?	
Do you consume alcohol?		If yes, how many units per week?	
Are you allergic to any foods or drinks			
<i>(Lab report from an Occupational Health Department or G.P Pathology report confirming your immunisation)</i>			
TYPE OF IMMUNISATION	YES	NO	DATES/RESULTS
Rubella ( <i>German Measles</i> )			
Measles <i>Disclaimer: I have/have not had measles</i>			<i>Signed:</i> _____ <i>Date:</i> _____
Hepatitis B ( <i>Including Titre Levels</i> ) <i>Or Antibody check</i>			1                      2                      3
Tuberculosis BCG/Scar			
Hepatitis C - Antibodies			
Immuno-deficiency Disorders (Inc HIV)			
Varicella - (Chicken Pox/Shingles) <i>Disclaimer: I confirm I had/had not suffered from this disease</i>			<i>Signed:</i> _____ <i>Date:</i> _____
Tetanus			
Poliomyelitis			

<b><i>I take full responsibility for entering into employment with Platinum before completing my full course of inoculations against Hepatitis B. I have been advised and am aware that the inoculations have to be completed,</i></b>	
Signed:	Date:
Do you agree to be health screened or to obtain a certificate of fitness from your G.P or an Occupational Health Service if required? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Name of G.P	Address & Telephone Number
<b><i>I Declare that I deem myself both physically and mentally fit to undertake the duties required for the role of a Healthcare Worker. If your health changes in anyway, please inform Platinum IMMEDIATELY. Failure to do so may invalidate your insurance</i></b>	
<b>Medical Screening</b>	
Have you got any history of any medical screening?	
Date of most recent screening and name of hospital/Trust	
Is there anything else you wish to inform Platinum about with regards to your health?	
<b><i>Verified by Registered</i></b>	
<b><i>Nurse Office Use Only</i></b>	
<b>OCCUPATIONAL HEALTH</b>	
Please note Platinum supplies staff to both NHS and private organisations and individuals. Any offer of work or assignments you receive via Platinum is conditional pending the successful completion of pre-employment	
Signed:	Date:

Application form checked and read by management.

Signed by Platinum Support and Care Services Limited management:

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Date:

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Please complete and return to:  
Platinum Support & Care Services  
27 Ann Street,  
Co. Antrim  
BT546AA

# Application Checklist

**Incomplete applications will not be accepted for processing.**

**Please bring the following documents to your registration meeting. Failure to provide the following may result in your application being delayed or cancelled:**

- Birth Certificate / Marriage Certificate
- Photographic ID (Passport, Full Driving Licence inc Paper Part, Electoral Identity Card)
- Confirmation of Car Insurance for Business Use
- Work Permit, Residency Permit, Indefinite Leave to Remain
- Proof of National Insurance Number
- Proof of Address (Utility Bill, Bank Statement)
- 1 Passport Photos
- Confirmation of Vaccinations
- Confirmation of NISSC





