

OAD ref No. \_\_\_\_\_

Branch: \_\_\_\_\_

Please affix photograph here

The other copy to be used for ID

**Please return form to Your Local Branch Office**

Application details accepted in our database ONLY after a face to face recruitment interview

## APPLICATION FOR EMPLOYMENT

Profile/Grade  (HCA, Nurse, Clerical etc)

Date

### I. PERSONAL DETAILS

TITLE.....

SURNAME.....

ADDRESS .....

OTHER NAMES.....

.....

DATE OF BIRTH .....

.....

MARITAL STATUS .....

.....

RELIGION.....

POSTCODE .....

NATIONAL INSURANCE NO. ....

TEL HOME .....

NATIONALITY .....

MOBILE .....

DRIVER YES/NO

EMAIL .....

REQUIRE WORK PERMIT? YES/NO

FAX .....

IF YES, EXPIRY DATE:.....

explain type of permit: .....

NEXT OF KIN .....

NEXT OF KIN ADDRESS .....

NEXT OF KIN TEL NO .....

NEXT OF KIN MOBILE NO .....

NEXT OF KIN EMAIL .....

RELATIONSHIP TO NEXT OF KIN .....

### 2. CRB CHECKS-NOT PORTABLE. WE ONLY ACCEPT MATCH OPTIONS CHECKS

APPLICATION REF:  DATE CRB APPLIED  DATE RECEIVED:

APPLIED FOR POVA?  DATE POVA APPLIED  DATE RECEIVED:

### 3. BANK DETAILS

NAME OF BANK .....

NAME OF ACCOUNT .....

BANK ADDRESS .....

SORT CODE .....

.....

ACCOUNT NO. ....

REF .....

#### 4. HEALTH SCREENING AND MEDICAL HISTORY

- a) Have you completed and signed the the attached Match Options Self declaration for fitness to work Questionnaire? **YES / NO**  
 If "YES" enclose a copy will be filed with this application form. if "NO", please complete one and attach with this application form
- b) Are you immune against the following?

HEPATITIS B	documentary proof required
HEPATITIS C (EXPOSURE PRONE)	documentary proof required
RUBELLA (GERMAN MEASLES)	documentary proof required
TB	documentary proof required
VARICELLA ( CHICKEN POX/ SHINGLES) - SELF DECLARATION	

**YES / NO**


Please note that the documentary proof have to be from a qualified occupation Health practitioner or your GP  
 You are required to be immune to above if you are to work in the NHS

NAME OF GP:	ADDRESS:
TELEPHONE:	
FAX:	

#### 5. QUALIFICATIONS

(Qualified Nurses Must also provide documentary details of their professional registration with NMC which will be placed in their personnel file)

	DATE	QUALIFICATION	COURSE TITLE	INSTITUTION	GRADE ATTAINED
1.					
2.					
3.					
4.					
5.					
6.					

<b>MANDATORY AND INDUCTION TRAINING</b> (This applies to all Healthcare workers):	DATE TRAINED	EXPIRY DATE
FIRE SAFETY AND PROCEDURES		
MANUAL HANDLING		
FIRST AID-BASIC LIFE SUPPORT		
HEALTH& SAFETY		
INFECTION PREVENTION & CONTROL-INCLUDE MRSA, CLOSTRIDIUM DIFFICILE ETC		
LONE WORKER TRAINING		
C&R -HANDLING OF VIOLENCE & AGGRESSION		
FOOD HYGIENE		

#### 6. PROFESSIONAL MEMBERSHIPS

	DATE ADMITTED	NAME OF BODY	DETAILS OF MEMBERSHIP	LEVEL
1.				
2.				
3.				
4.				
5.				

Note that it is your responsibility to inform Match Options recruitment when you are suspended /removed from list or under investigation from that professional body

**7. WORK HISTORY/EXPERIENCE AND REFERENCES**

(note this is also authority for us to ask for references from your most recent employer. We need you to complete a minimal continuous 5 years history. If not worked at some time in this period, please provide explanation for any gaps. We need at least 2 past employers to give us a reference.)

Date from-to	Employer's Name	Address	Contact	Title

Please also provide details of a work colleague who will give us your character reference.

NAMES:	ADDRESS:
TELEPHONE	
EMAIL:	
Give details of any major medical condition or continuous medication:	

**8. WORK PREFERENCES**

Please use this space to tell us if you have any work preferences-shifts, location etc.

Is there anything you would wish to add not covered above?.

**9. DECLARATION**

a) Declaration of offenders Act 1974-You are not entitled to withhold information regarded as "spent" under the act. This is due to the nature of work of the post which may be exempt from sec.4(2).

Any information which you give will be treated in strict confidence and in accordance with the data protection Act, which Match Options adheres and complies with.

Have you ever been convicted of a criminal offence? YES / NO

If "YES", please provide details of all convictions and cautions, including those considered "spent"

b) By signing this application form, you also declare that to the best of your knowledge:

- i) All information is my full disclosure including that which might be omitted by the CRB/ POVA check.
- ii) I will inform Match Options any time that I am not of good health and not fit before starting for any work placement offered.
- iii) I have been made aware of my responsibility to prevent myself from infectious environments and among others issued with handouts covered at clause 4 above,POVA, MRSA,Clostridium Difficile,HSC 1998/226 on AIDS/HIV,Protection of Children, Health & Safety and Manual Handling
- iv) issued with a contract of employment, Staff handbook in which I was made aware of the company policies and procedures contained therein and not limited to Complaints, grievances and disciplinary,general conduct,Timesheets and payroll issues including working time regulations etc
- v) To comply with the Mandatory Training, performance appraisal procedures in place from time to time
- vi) That Match Options has the right to withhold payment against revenue lost due to my negligence and non coverage of placements per contract of employment.

Name: Sign and Date

**10.FITNESS TO WORK CERTIFICATE**

A copy of this questionnaire has to be presented to your GP, a local NHS Trust or a qualified occupation Health Practitioner. Ask for a fresh copy if do not intend to take this one to the practitioner.with your certificates of Immunisation, they will be able to certify that you are fit to work in the position you have applied for.

Surname:	Other Names:
Gender: Male / Female	Date of Birth:
Nationality:	Position Applied:

**Exposure Levels - Please mark areas below that you believe are applicable to position you applied**

Exposure to chemicals	Yes	No	Driving	Yes	No
Working in Confined space	Yes	No	Contact with Client for Personal Care	Yes	No
Night work	Yes	No	Exposure to Blood or body fluids	Yes	No
Shift rotation	Yes	No	Moving, Lifting & Handling of Client	Yes	No
Radiation	Yes	No	Moving, Lifting & Handling of other objects	Yes	No
Pharmacy	Yes	No	Exposure Prone Invasive Procedures (EPIP)	Yes	No
Substantial access to children	Yes	No	Food Handling	Yes	No
Visual Display screen user (continuously more than 1 hr/day)	Yes	No	Working at Heights	Yes	No

If you have ever felt that working at night is harmful to your health, please state here:

If you have felt that you have a medical condition that may affect your working at night, please state here:

How many days have you lost from work in the past year?

Please state what was this loss due to:

**MEDICAL HISTORY:** Please answer ALL questions

DO YOU, OR HAVE YOU EVER SUFFERED FROM? (if yes, please give details):

Any impairment that may affect your ability to work or perform duties safely?	YES/NO	
Eyesight problems not corrected by Glasses /contact lenses?	YES/NO	
Difficulties in Walking, bending, lifting or any other movement?	YES/NO	
Difficulties in hearing not correctable by hearing aid?	YES/NO	
Muscular-skeletal problems, including Arthritis or a back problem?	YES/NO	
Significant discomfort when using a keyboard?	YES/NO	
Psychological conditions including stress at work?	YES/NO	
Fits/blackouts or epilepsy?	YES/NO	
Suffered any accidents that significantly affected you physically or mentally?	YES/NO	
Suffered from Asthma, Bronchitis or serious chest problems?	YES/NO	
Treated for Tuberculosis?	YES/NO	
Gastrointestinal problems including Hepatitis?	YES/NO	
Diabetes, Thyroid or endocrine problems	YES/NO	
Cardio-vascular problems including hypertension or a blood disorder?	YES/NO	
Dysentery, Typhoid, Paratyphoid ,food poisoning, salmonella, severe gastroenteritis or diarrhoea?	YES/NO	
Had an operation in the past 2 yearS?	YES/NO	
If you are under any medication (please give name of drug and dosage)	YES/NO	
Are you waiting for any medical treatment, investigation or test at the moment?	YES/NO	
Have you ever suffered from any serious/frequent headaches or episodes of migraine?	YES/NO	
Do you think you had any illness that was made worse by your work?	YES/NO	
Have you ever had any drug or alcohol problem?	YES/NO	
Do you consider yourself as having any disability?	YES/NO	
Have ever had any concern/fear that you may have a health problem?	YES/NO	
Coughs/Vomiting/diarrhoea/Rash-In the last 12 months, have you had a cough for more than 3 months, ever coughed/Vomiting/diarrhoea/Rash blood or any unexplained loss of weight or fever?	YES/NO	

Allergies-state here if any:

Do you have any more relevant medical information you think is not covered above? If yes, please state here or continue on a separate sheet of paper:

**SELF DECLARATION BY APPLICANT**

1. I declare that the information provided on this questionnaire is true to the best of my knowledge and accept that it will form the basis upon which the Qualified medical practitioner will base the certification as to my fitness to work for the position applied for.

2. I also state that I will inform Match Options Recruitment of any changes that may occur that may affect my ability to work for the position applied for.

3. I understand that it is my responsibility to ensure that all information provided is based on my truthfulness and that if I fail to notify Match Options Recruitment of any changes that may occur at any time, Match Options Recruitment may at their choice cease placing me for job vacancies.

4. I accept that my personal details will be safely stored and handled by Match Options Recruitment in accordance with the Data protection Act 1998, and that the same may be made available for Audit/Review by relevant organisation like NHS PASA, CSCi and where by law necessary the company's service users.

5. I understand that I am required to declare when unfit (including when suffering from Vomiting, Diarrhoea or a rash before accepting any placement).

6. I also understand that all Female workers must declare when they become Pregnant.

7. I understand that a service user may require me to undergo a medical check up before commencement of an assignment

8. I confirm that I have been made aware and been issued with fact sheets on: AIDS/HIV, ( HSC 1998/226), MRSA, Varicella, Clostridium Difficile, POVA, Prevention of abuse of children and that I will undertake necessary training when asked by the company.

9. I confirm that I have received a Job description/specification which enabled me to complete the above questionnaire for the part relating to Exposure levels.

NAMES:

SIGNATURE:

DATE:

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**TO BE COMPLETED BY THE PROFESSIONAL PRACTITIONER AS A CERTIFICATE**

This is to certify that based on above questionnaire and certificates/records of immunisation produced, and relevant to the the position applied, I consider applicant fit to work.

Tick certificates seen or any pathological tests done here-

Hepatitis B	Hepatitis C	Varicella	Rubella	TB	other( State)_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Names:

Signature:

Qualifications:

Date:

Any comments:

Please insert Company stamp and address here