

**REGISTERED NURSE APPLICATION FORM Tel: 020 8240 4499**

***PLEASE ENSURE YOU COMPLETE ALL SECTIONS OF THIS FORM* registration@peglobal.co.uk**

**Date of application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PERSONAL DETAILS**

Position applied for: RGN  RMN  SPECIALITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Title: (Mr MRS MISS Ms )**

First Name(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Known as: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NI Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you hold a current valid driving licence: Yes / No

Do you have use of a car Yes /No

Nationality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Passport Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Issue: \_\_/\_\_/\_\_\_\_\_ Date of Expiry: \_\_ / \_\_ /\_\_\_\_\_

I confirm I have the Right to Work in the UK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_ / \_\_ / \_\_\_\_\_

Signature

**PROFESSIONAL REGISTRATION**

NMC pin number: \_\_\_\_\_\_\_\_ \_\_\_\_ NMC expiry date: \_\_\_/ \_\_\_/\_\_\_\_\_ NMC Part(s) of register:\_\_\_\_\_\_\_\_\_\_\_\_\_

Union Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Membership Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Details:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to You: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mr/Mrs/Miss/Ms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reference 1:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In what capacity is this person known to you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company Name/Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Dates: From: \_\_\_/\_\_/\_\_\_\_ To: \_\_\_/\_\_/\_\_\_\_

**Reference 2:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In what capacity is this person known to you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company Name/Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Dates: From: \_\_\_/\_\_/\_\_\_\_ To: \_\_\_/\_\_/\_\_\_\_

**Reference 3:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In what capacity is this person known to you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company Name/Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Dates: From: \_\_\_/\_\_/\_\_\_\_ To: \_\_\_/\_\_/\_\_\_\_

**I hereby give permission for my referees to be contacted and for my references to be shared with third parties if relevant**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_ / \_\_ / \_\_\_\_\_**

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

**REFEREES**

*Please supply names and address of minimum 2 referees, one should be from your most recent employer*

**EMPLOYMENT HISTORY**

**Please confirm that you have supplied a copy of your CV giving full employment details, covering a minimum of 10 years or back to your Qualification as a Registered Nurse.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_**

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**CLINICAL EXPERIENCE**

*PLEASE TICK AND INITIAL ALL AREAS WHERE YOU ARE COMPETENT / HAVE CLINICAL EXPERIENCE*

|  |  |  |  |
| --- | --- | --- | --- |
| **A&E** | **Acute Mental Health** | **CCU/HDU** | **Cardiology** |
| **Catheterisation** | **Community Nurse** | **Chemotherapy** | **CPN** |
| **Dementia Nurse** | **Elderly Care** | **Gynaecology** | **Haematology** |
| **Health Visitor** | **ITU** | **Midwifery** | **Neonates** |
| **NICU** | **ODP/Scrub Nurse** | **Occupational Health** | **Orthopaedics Radiology** |
| **Oncology** | **Practice Nurse** | **Palliative Care** | **Prison Nurse** |
| **Paediatric A&E** | **PICU** | **Pressure Bandaging (with Doppler** | **Radiology** |
| **Renal** | **Re-ablement** | **Sexual Health** | **Spinal Injury** |
| **Stroke Rehabilitation** | **Triage** | **Urology** | **Venepuncture** |
| **Wound Care** | **Other** | **Other** | **Other** |
| **Other** | **Other** | **Other** | **Other** |

**DBS APPLICATION** *\*\*Please provide 5 years continuous address history with NO gaps*

*NB If you have a DBS registered with the DBA Update Service, you do NOT need to complete this section*

|  |  |  |  |
| --- | --- | --- | --- |
| **Title:** | **Forename(s):** | | **Surname/Family Name:** |
| **Are you currently, or have you ever been known by any other name YES / NO**  **If Yes, Please list all names below and dates when you changed your name:**  **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Name Change: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Name Change: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Current Home Address:**  **Post Code: \_\_\_\_\_\_\_\_\_\_ Date Moved Here: (MM/YYYY)** | | **Previous Address:**  **Post Code: \_\_\_\_\_\_\_\_\_\_ Date Moved Here: (MM/YYYY)** | |
| **Previous Address**  **Post Code: \_\_\_\_\_\_\_\_\_\_ Date Moved Here: (MM/YYYY)** | | **Previous Address**  **Post Code: \_\_\_\_\_\_\_\_\_\_ Date Moved Here: (MM/YYYY)** | |
| **Previous Address**  **Post Code: \_\_\_\_\_\_\_\_\_\_ Date Moved Here: (MM/YYYY)** | | **Previous Address**  **Post Code: \_\_\_\_\_\_\_\_\_\_ Date Moved Here: (MM/YYYY)** | |
| **Nationality at Birth** | **Current Nationality** | | **Passport Number & Country of Issue:** |
| **Mothers Maiden Name:** |  | | **Date of change of Nationality:** |
| **National Identity Card Number & Country of Issue:** | | | |
| **Have you ever been convicted of a criminal or civil offence? If yes, please give details:** | | | |
| **Have you ever received a police caution? If yes, please give details:** | | | |
| **National Insurance Number:** | | **Driving Licence Number & Country of Issue:** | |

**I Authorise PE Global Healthcare to carry out an online DBS check on my behalf using the information I have provided.**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BANK DETAILS**

**Name of Account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Bank: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Branch Address : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACCOUNT NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SORT CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This is my: PERSONAL BANK ACCOUNT  LTD COMPANY BANK ACCOUNT **

**PAYMENT METHOD:**

**I wish to be paid by: PAYE  Ltd Company\*\*  Umbrella Organisation **

**I have provided my P45  P46 **

**\*\* If you have your own Ltd Company, you MUST provide a copy of your Certificate of Incorporation, company Bank details and proof of Indemnity Insurance. We can NOT make payments into a personal Bank Account.**

**Limited Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Registered Company Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Company Registration Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I CONFIRM I HAVE FULL PROFESSIONAL MEDICAL INDEMNITY INSURANCE WITH:**

**RCN / Unison / Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please note that we will pay you weekly in arrears into your nominated account. You will receive a payslip by email in advance.**

**If you have a Limited Company, you must submit a weekly invoice along with your timesheet**

**I confirm the details I have provided are accurate and I wish to be paid by the method I have selected above:**

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

**REHABILITATION OF OFFENDERS**

The position you are applying for (whether paid or voluntary) is listed in Schedule 1, Part II of the

Rehabilitation of Offenders Act (Exceptions) Order 1975, so we are entitled to ask Exempted Questions as defined by Section 113(5) of The Police Act 1997 about you.

The nature of the work placements offered by us means the terms of Section 4 part 2 of the Rehabilitation of Offenders act (1974) (exceptions) Order 1975, apply. You must declare here any convictions or cautions you have ever received, even those which would normally be considered spent.

Have you ever received a Criminal Conviction? **YES / NO** Have you ever received a Police Caution**? YES / NO**

Are you, as far as you know, under investigation by the Police**? YES / NO**

Do you have any Prosecutions pending**? YES / NO**

Has there ever been a suggestion that you are unsuitable to work with Vulnerable People**? YES / NO**

If you have answered YES to any of the above, please provide a full written statement with your application form. Any information you provide will be treated in the strictest confidence.

I understand that my DBS Certificate information may be shared with any Client considering employing me on a temporary or permanent basis. I will inform PE Global Healthcare immediately if anything changes that would affect my answers to the above.

**Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WORKING TIME REGULATIONS**

I, the undersigned, agree with PE Global Healthcare that the limit in regulation 4(1) of The Working Time Regulations Act 1998 shall **not** apply to me and that my average working time may therefore exceed 48 hours for each seven-day period (as defined by and calculated in accordance with The Working Time Regulations 1998)

I agree that I shall comply with any and all policies of the employer which relate to the maintenance of records of my hours of work. This agreement can be terminated by me giving one months’ notice in writing to the employer. The agreement shall apply from today’s date until further notice

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATA PROTECTION**

I understand that PE Global Healthcare may hold data about me, whether obtained directly from me or from other sources, and that some of this data may be sensitive. This data may be held indefinitely, and I give my permission for this data to be disclosed to third parties in the course of seeking employment or training for me.

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DECLARATION OF ACCURACY**

I hereby confirm that the information provided on this Application form is, to the best of my knowledge, complete and accurate in all respects. I understand that knowingly providing false information will automatically result in de-registration with PE Global Healthcare.

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please provide details of your GP:**

We will only contact your GP with your permission

GP Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***INTERVIEW***

***Please bring the following documents with you to your interview. You will be sent full details of when and where to attend by email. If you have any questions regarding your interview, please call PE Global Healthcare on: 0208 240 4499***

***Interview Checklist:***

*Full working History / CV Current Mandatory Training certificates*

*1 Recent Passport Photos Driving Licence if driving to/from work*

*Passport / Visa 2 Proofs of Address less than 3 months old*

*EU Card (if applicable) (Bank Statements, Utility Bills in your name)*

*Original Birth Certificate Blood results showing immunity to Hepatitis B*

*Marriage /Divorce Certificate if name changed)*  *Varicella, Rubella and measles as a minimum*

*Proof of National Insurance Number Proof of TB scar*

*Original Qualification Certificate Current DBS (if registered online with update service)*

*NMC Statement of Entry*