

 Unit 24 Vikings Way, Canvey Island, Essex SS8 0PB

 **BPRO NURSING LTD APPLICATION FORM**

**Phone:** 01268952767 / 07930173291 **Web:** www.bpronursing.co.uk

**Email:** info@bpronursing.co.uk

**Position applied for**:

Please tick: RGN/RMN

 HCA

 Support Worker

|  |
| --- |
|   |

 Midwife

 **PERSONAL INFORMATION**

|  |
| --- |
| Title: Mr/Mrs/Miss/Ms/Other  |
| Surname:  |
| Forenames:  |
| Home address:  |
|   |
| Postcode:  |
| Tel. No.  |
| Mobile:  |
| Email:  |
| National Insurance Number:  |

 **GENERAL INFORMATION**

|  |
| --- |
| Sex: Male: Female:  |
| Nationality:   |
| Country of Birth:   |
| Date of Birth:   |
| Religion:   |
| Do you have a car:   |
| Do you hold a full UK driving Licence:   |
| Are you happy to take public transport if necessary   |

 **NEXT OF KIN DETAILS**

|  |
| --- |
| Next of Kin Name:   |
| Address:   |
|    |
|    |
| Home Tel. No.   |
| Work Tel. No   |
| Mobile:   |
| Relationship to you:    |

 **IMMIGRATION STATUS**

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| --- |
| Are you legally eligible to work in the UK?    |
| Do you have British Citizenship?    |
| Are you an EEA National?     |
| Do you hold a work Permit?     |
| Issue Date of Work Permit?     |
| Type of work permit:     |
| Passport No: U.K Entry Date  |

 **EDUCATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Name & Address of School  | From  |  To  |  Qualifications  |
|          |   |   |   |
|         |   |   |   |
|        |   |   |   |

**Please complete full employment history since leaving school. Explain any gaps**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Employer Name&address  | Position held including Responsibilities  | From  | To  | Reason for leaving  |
|         |   |  |  |  |
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 **EXPERIENCE (HCAs and Support Workers)**

**Please tick if competent in any of the following:**

|  |  |  |  |
| --- | --- | --- | --- |
|  **Personal Hygiene**  |  | **Observations**  |  |
| Bath  |  | Blood pressure  |  |
| Shower  |  | Pulse  |  |
| Strip shower  |  | Respiration  |  |
| Bed Bath  |  | Temperature  |  |
| Use of bath aids  |  | Testing  |  |
| Eye care  |  | Observing and recording changes  |  |
| Care of feet, excluding toe nails  |  |  |  |
| Care of Hair  |  | **Nutrition**  |  |
| Mouth Care  |  | Feeding  |  |
| Dressing/undressing  |  | Food Handling  |  |
| Shaving  |  | Preparing meals  |  |
|  |  |  |  |
| **Toileting**  |  | **Mobility**  |  |
| Bed pans, Commodes etc  |  | Moving and handling of Clients  |  |
| Emptying a catheter bag  |  | Use of Hoists,Manual and Electric  |  |
| Changing a catheter bag  |  | Use of a Wheelchair  |  |
| Continence Care  |  |  |  |
| Stoma Care  |  | **Areas of specialisation**  |  |
|   |  | Dementia  |  |
| **Care Duties**  |  | Spinal/Head injuries  |  |
| Assisting with medication  |  | Multiple sclerosis  |  |
| Pressure area care  |  | A&E  |  |
| Simple Dressing procedures  |  | Clinics  |  |
| Terminal Care  |  | Opthalmic  |  |
| Bed making and changing Bed  |  |  |  |
| Light Housework  |  |  |  |
| Shopping  |  |  |  |
| Washing/Personal Laundry  |  |  |  |
|   |  |  |  |
|   |  |  |  |

 **TRAINED NURSES**

 **Please tick if competent in any of the following:**

|  |  |  |  |
| --- | --- | --- | --- |
| Surgical (e.g. Cardiac, Thoracic, Neuro, E.N.T)  |   | Paediatrics  |  |
| Medical  |   | SCUBU  |  |
| Orthopaedics  |   | Midwifery  |  |
| Neurology  |   | Family Planning  |  |
| Gynaecology  |   | District Community Nursing  |  |
| Oncology  |   | Palliative care  |  |
| Cardiology  |   | Phlebotomy  |  |
| Cardiothoracic  |   | Haematology  |  |
| Elderly care  |   | Infectious Diseases  |  |
| Theatres  |   | Health Visiting  |  |
| Recovery  |   | Occupational Health  |  |
| E.N.T  |   | Mental Health  |  |
| ITU  |   | Psychiatry  |  |
| HDU  |   | Other:-Please list below  |  |
| CCU  |   |   |  |
| **A&E**  |  |  |  |

 **PLEASE GIVE DETAILS OF YOUR PROFESSIONAL TRAINING:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Training School/Centre**  | **From**  | **To**  | **Qualifications**  |
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|  **MEMBERSHIP OF PROFESSIONAL BODIES**  Name of Body:  |
| Address:  |
|   |
|   |
| Postcode:  |
| Personal Identification Number (PIN):  |
| PIN expiry:  |
| Qualifications:  |
|   |

 **REFERENCES**

Please give details of two references: one must be your current/most recent employer of a more senior position than you (school/college for students; work address only).

Please note it is our policy to request references prior to interview.

Please tick here if you do not wish us to request references at this stage.

**REFERENCE 1 REFERENCE 2**

|  |  |
| --- | --- |
| Name  | Name  |
| Address  | Address  |
|  |   |
|  |   |
|  |   |
| Email: | Email: |
| Tel. No.  | Tel. No.  |
| Position Held  | Position Held  |
| Relationship  | Relationship  |

 **REHABILITATION OF OFFENDERS ACT 1974**

Please be aware that service providers in medical area practice are exempt from the provision of the Rehabilitation of Offenders Act 1974. You are therefore not entitled to withhold any information about spent convictions. Any and all information will be treated confidentially and only considered in relation to this application.

Have you ever been convicted or cautioned for criminal Offence?

If yes, please give details and state if a conviction or Caution:

|  |
| --- |
|      |

**DATA PROTECTION ACT**

BPro Nursing Ltd are required to hold personal information on all staff members i.e. Address, Date of Birth, National Insurance Number etc, including Rehabilitation of Offenders Information.

Please note that Regulatory bodies may wish to access Personal Files for inspection purposes in order to verify compliance with legislation and regulations. Please sign below giving your consent for your file to be inspected.

|  |
| --- |
| Applicant’s signature:     |
| Date:     |

 **DECLARATION**

The information that I have given in my application is, to the best of my knowledge, accurate and complete. I understand that if I have knowingly given false information it will result in my application being terminated.

I also understand/agree that it is my responsibility to update BPro Nursing Ltd of any changes.

|  |
| --- |
| Applicant’s signature:     |
| Date:      |