Breath of Life Medi-Care Group
Supplying Health Care Professionals

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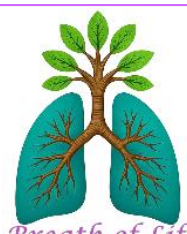

APPLICATION FORM

PLEASE READ INSTRUCTION

Please note all fields marked with (*) are mandatory. If any field is left uncompleted, this will invalidate the form.
Once completed, please email or send by post to our company's registered address please.

Title:……..

Surname:…… First name:…….

Middle name(s):……. Date of Birth:……

Male:…….. Female:…….

Others:……

Residence Address

House name or no:…….. Street:…….

Town:…….. Country:…….

County:…… Post Code:……..

Telephone: Home:…….. Mobile Tel:.....

Work Tel:..... Live in Address since:……

Email:……..

Emergency Contact:

Full Name:……... Relationship:……...

Home Tel:..... Mobile Tel:.....

Job / Position for application

What job/s are you applying for?

Are you registered with any professional bodies? (Please tick as appropriate)

HCPC ☐ NMC ☐ GMC ☐ GPhC ☐ RCCP ☐ Others ☐ N/A ☐

If others: Name of professional body:

Name: . . . . . .

Your Registration number: . . . . . Date of Expiry: . . . . . Renewal: . . . . . .

Any Professional Indemnity Insurance:

Provider: . . . . . .

Policy Number: . . . . . Expiry date: . . . . . .

Nationality and Eligibility to Work

Do you hold a British /EU passport ? Yes ☐ No ☐

Nationality: . . . . . .

Passport no: . . . . . .

If you do not hold a British/EU passport ? Yes ☐ No ☐

Do you hold any of the following :

Indefinite Leave to Remain in the UK ☐ Work Permit/Sponsorship (Tier 2) ☐

Spousal/Partnership Visa ☐ Student Visa (Tier 4) ☐

Biometric Residence Permit ☐ Ancestry Visa ☐

Working Holiday Visa/Youth Mobility (Tier 5) ☐

Others (Please specify): . . . . . .

Expiry Date: . . . . . .

Evidence is required of all Passports and Visas. Please enclose or send scanned copies or photocopies with this application and bring the originals to your first interview. To work in the NHS you will be expected to communicate proficiently in English. All passports and Visas will be verified as part of our recruitment procedure.

Professional Qualifications / Appraisal

List all professional qualifications held and training courses undertaken, including Post Graduate Diploma/Courses etc. Professional qualifications and training will be verified. Continue on a separate sheet if necessary.

Please provide scanned copies/photocopies of all certificates.

Qualification	Place where obtained	Date to/from	Certificate attached ?
Appraisal:			

Training

You are required to complete the following practical training on an annual basis.
(Please tick the relevant courses you have completed and that you will be sending to us a valid original certificate)

Training	**Place where obtained**	**Date to/from**	**Certificate attached ?**
Manual Handling			
Basic life support			
Immediate Life Support (if applicable)			
Food Hygiene			
Safeguarding Children and Young People (POCA) Level 2			
Safeguarding Children and Young People (POCA) level 3			
Protection of vulnerable Adults (POVA)			
Complaints handling			
COSHH			
Fire and Safety			
Health and Safety			
RIDDOR/Risk Incident Reporting			
Violence and Aggression			
Information Governance, Data Protection and Caldicot Protocol			
Infection Control (including Clostridium Difficle and MRSA)			
Lone Worker Training			
Additional Training			
Additional Training			
Additional Training			

EMPLOYMENT HISTORY

MOST RECENT FIRST. Please list the last 10 years of your employment, including secondary school. It is important that you explain any gaps of employment of over 1 month in duration. In addition, please attach your current CV.

Employer's details

From (Month/Year):	To (Month/Year):
Employer:	Location (Ward/Dept):
Job Title:	Telephone No:
Grade/Band:	Email:

Employer's details

From (Month/Year):	To (Month/Year):
Employer:	Location (Ward/Dept):
Job Title:	Telephone No:
Grade/Band:	Email:

Employer's details

From (Month/Year):	To (Month/Year):
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Job Title:	Telephone No:
Grade/Band:	Email:

PROFESSIONAL REFERENCES

Please give the names and contact details of 3 professional referees from your current and most recent employment, which must cover the last 5 years of employment/education. Referees must have worked in a senior position to yourself. Please be aware that, Breath of Life Medi-Care Group are unable to offer you work until satisfactory references have been obtained, and that Breath of Life Medi-care group are required to obtain references for you on an annual basis. Please continue on a separate sheet if necessary.

Reference 1

Organisation: . . . .
Job title: . . . . Ward/Dept: . . . .
Grade/Band: . . . . Dates Employed (Month/Year): . . . .
Referee name: . . . . Professional title: . . . .
Email: . . . . Telephone: . . . .
Capacity in which known (i.e. Manager): . . . .
Can we contact prior to Interview: Yes: ☐ No: ☐

Reference 1

Organisation: . . . .
Job title: . . . . Ward/Dept: . . . .
Grade/Band: . . . . Dates Employed (Month/Year): . . . .
Referee name: . . . . Professional title: . . . .
Email: . . . . Telephone: . . . .
Capacity in which known (i.e. Manager): . . . .
Can we contact prior to Interview: Yes: ☐ No: ☐

Reference 1

Organisation: . . . .
Job title: . . . . Ward/Dept: . . . .
Grade/Band: . . . . Dates Employed (Month/Year): . . . .
Referee name: . . . . Professional title: . . . .
Email: . . . . Telephone: . . . .
Capacity in which known (i.e. Manager): . . . .
Can we contact prior to Interview: Yes: ☐ No: ☐

Payment Details

National Insurance Number: . . . . . .

Do you wish to nominate an umbrella company ? Yes ☐ No ☐

Do you wish to work as a limited company? Yes ☐ No ☐

Please provide a copy of your: (Please tick)

VAT Certificate	☐	Company's Certificate of Incorporation	☐
Corporation tax details	☐	Certificate of Insurance	☐
Company bank details	☐	PAYE Registration numbers	☐

Declaration of Criminal Record

Applicants for Healthcare positions are exempt from the Rehabilitation of Offenders Act 1974. You are then required to declare prosecutions or convictions, including those considered 'spent' under this Act.
Please tick as appropriate:

1- Do you have any convictions, cautions, reprimands or final warnings that are not "protected" as defined by the Rehabilitation of Offenders Act 1974 (Exemptions). Order 1975 (as amended in 2013) by SI 2013 1198?	Yes ☐ No ☐
2- Do you have any convictions, cautions, reprimands or final warnings which would not be filtered in line with current guidance?	Yes ☐ No ☐
3- Have you had a police check in another country within the last 6 months? If so, please provide details below and enclose a copy if held.	Yes ☐ No ☐
4- Have you ever been suspended or are you currently under investigation by an NHS Trust, professional body or any other organisation?	Yes ☐ No ☐

If Yes, Please provide details below:

5- Have you ever had an Enhanced Disclosure and Barring Service (DBS) check? formerly Criminal Records Bureau check or CRB).

Disclosure No: . . .. Date: . . . .

Company that conducted the check: . . . .

If you have signed up for the DBS Update Service, please provide the details of your DBS number: . . . . . .

Breath of Life Medi-Care Group will undertake an Enhanced DBS check on your behalf. You will not be placed without having completed a current DBS check. Breath of Life Medi-Care Group utilises the DBS e-Bulk service. Please contact your recruitment team to check the process for completing the DBS application online. Please enclose all ORIGINAL documentation (e.g. passport) as requested, not just photocopies. These will be returned to you immediately. Please note that at any stage whilst working for Breath of Life Medi-Care Group we receive a DBS enhanced disclosure that highlights information you have not declared then you will be removed from your assignment.

DECLARATIONS

Working Time Directive

The Working Time Regulations 1998 require Breath of Life Medi-Care Group to limit your average weekly working time to 48 hours unless you agree with Breath of Life Medi-Care Group that the limit shall not apply to you:
I agree to limit my working week to no more than 48 hours ☐ I disagree to limit my working week to no more than 48 hours ☐

Candidate Handbook

Please download, print and sign the Candidate Handbook from our website. You will need to return this with the application pack. The link to it is www.breathoflifemedicaregroup.com/candidates/document-downloads

I can confirm that I received, read and understood each section of the Candidate Handbook:

Before you start a temporary assignment	☐	Assignments	☐
Policies and Procedures	☐	Appraisals and Training	☐
Benefits of working for B Medi-Care group	☐		

I can confirm that I have read this document fully and that all the information provided to Breath of Life Medi-Care Group is correct and to the best of my knowledge and belief. I give consent to contact referees regarding the information I have provided unless specified otherwise.
I will inform Breath of Life Medi-care Group should anything change that might affect my position and I understand the information given on this form will be processed by computer and used for registration purposes, under the Data Protection Act 1998.

Declarations

1. I understand that if I am at any stage charged or cautioned after signing this declaration, I must inform Breath of Life Medi-Care Group.
2. I acknowledge that I have been given a copy of the terms and conditions of service issued by Breath of Life Medi-Care Group, which is mine to keep, and furthermore that I have read those terms and conditions and agree to abide by them.
3. I am not aware of any condition, medical or otherwise, which would affect or limit my employment or performance, other than those declared in my Occupational Health Form.
4. I acknowledge and confirm that Breath of Life Medi-Care Group is authorised to apply for and obtain a Disclosure and Barring Service (DBS) check and references from any previous employers and educational establishments.
5. I declare that the information given herein is true and complete and is not presented in a way intended to mislead. I agree that if I have given false or misleading information or omit to give relevant information now or in the future that Breath of Life Medi-Care Group may cease to offer me further agency placements without notice, as well as claim for recovery of any payments I have received, together with a claim for loss of profit to Breath of Life Medi-Care Group.
6. I agree that the maximum weekly working time specified in Regulation 4(1) and (2) of the Working Time Regulations 1998 shall not apply to working with Breath of Life Medi-Care Group unless specified above.
7. I acknowledge that my personal details will be stored and handled correctly by Breath of Life Medi-Care Group in accordance with the Data Protection Act 1998, however, I agree that they may be made available for audit/review by relevant third parties. (This is relevant for all information including all documents - DBS, Occupational Health, References).
8. I understand that if I am on a student visa I can only work for 20 hours per week during term time. I understand that I have a responsibility to monitor this. In addition, if my position as a student changes, I must inform Breath of Life Medi-Care Group.
9. I understand that if I am on a Tier 2 Sponsorship Visa, I can only work for a maximum of 20 hours per week at the same professional level as my sponsorship. I understand that I have a responsibility to monitor this. In addition, if my position with my sponsored company changes, I must inform Breath of Life Medi-Care Group.
10. I acknowledge that if any of my details stated on this Application Form change, or my circumstances change, which may affect my ability to work for Breath of Life Medi-Care Group, I must inform Breath of Life Medi-Care Group immediately.
11. I confirm that I am not currently under investigation, or currently suspended, by my professional regulatory body or being investigated by my current or previous employer. I will inform Breath of Life Medi-Care Group if I am under investigation or suspended by my professional regulatory body or employer at any point while working for Breath of Life Medi-Care Group.
12. I confirm that when asked about my working history (primarily, but not exclusively, for the purpose of the Agency Workers Regulations) I will provide accurate information.
13. I acknowledge that should I reach the 12 week Qualifying Period under the Agency Workers Regulations, I may be asked for, and will provide, further documentation as evidence of qualifying weeks, if Breath of Life Medi-Care Group deem it necessary.

Signature: . . . . . .

Print Name: . . . . . .

Date: . . . . . .