

Office Use;  
Staff number;

Unit 12D  
West Station Yard, Spital Road,  
Maldon, Essex, CM9 6TR.

Telephone; 01621 843485  
E-Mail; [enquiries@mikeriglinnursing.co.uk](mailto:enquiries@mikeriglinnursing.co.uk)

**REGISTERED NURSE APPLICATION**

SURNAME..... (Mr/Mrs/Ms/Miss)	NATIONALITY.....
FORNAMES.....	COPY OF PASSPORT: YES/NO EXPIRY DATE.....
MAIDEN NAME.....	VISA (NOT WORK PERMIT); YES/NO EXPIRY DATE.....
ADDRESS.....	(Non British Citizens must provide proof of immigration Status/eligibility to work in the UK)
.....	
POST CODE.....	PIN REGISTRATION NUMBER ..... EXPIRY DATE ; .....
TELEPHONE NUMBER.....	DBS DISCLOSURE (identification documents required as per attached list – cost fee of £50.00 payable at time of process)
MOBILE.....	<b>A new application is compulsory for all new staff.</b>
DATE OF BIRTH.....	DOCUMENTATION FOR CURRENT IMMUNISATION STATUS
NATIONAL INSURANCE NO. ....	YES/NO (compulsory, request from your G.P Surgery or occupational Health department as soon as possible)
EMAIL ADDRESS.....	
FULL UK DRIVING LICENCE YES/NO	WORK PREFERENCES; What times/days do you prefer to work?
CAR DRIVER/OWNER YES/NO	.....
NEXT OF KIN.....	QUALIFICATIONS/ EXPERIENCE/COURSES ATTENDED; (Please detail, including dates, continue onto additional paper if required)
RELATIONSHIP.....	OR IF FULL DETAILS SHOWN, REFER TO C.V.
ADRESS.....	.....
TELEPHONE NO. ....	.....
HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENCE? *YES/NO	.....
ANY PROSECUTIONS PENDING? * YES/NO	.....
(*details of any convictions/cautions required – please Detail overleaf)	.....

EMPLOYMENT DETAILS (To cover your full work history – If there are gaps please detail reasons below. If full employment details shown, please refer to C.V.)

(1) EMPLOYERS NAME AND ADDRESS DATE FROM ..... TO.....  
.....  
..... TELEPHONE; .....  
..... POSITION HELD .....

(2) EMPLOYERS NAME AND ADDRESS DATE FROM..... TO.....  
.....  
..... TELEPHONE .....  
..... POSITION HELD .....

(3) EMPLOYERS NAME AND ADDRESS DATE FROM ..... TO .....  
.....  
..... TELEPHONE .....  
..... POSITION HELD .....

**Please continue overleaf if necessary**

HAVE YOU HAD ANY GAPS IN YOUR EMPLOYMENT HISTORY? YES/NO (IF YES PLEASE DETAIL BELOW)

.....  
.....

HOW MANY DAYS SICKNESS HAVE YOU HAD IN THE LAST YEAR? .....

WILL THIS BE YOUR ONLY EMPLOYMENT? YES/NO

HOW DID YOU HEAR ABOUT THE AGENCY? .....

**REFERENCES** Names and address of three referees (for professional referee we will require full business address, not private residence please and professional reference should be an employer, senior staff member/line manager – not a colleague/friend)

**(Most recent employer, not less than 3 months)**

**(Previous employer, not less than 3 months)**

1. ....  
.....  
.....  
.....  
.....  
Tel/Fax No.....  
Email .....

2 .....  
.....  
.....  
.....  
.....  
Tel/Fax No.....  
Email .....

**3. (Character Referee)**

.....  
.....  
.....  
.....  
.....  
Tel/Fax No.....  
Email.....

**PAYMENT/BANK DETAILS FORM**

WE PAY FORTNIGHTLY BY BACS (BANKERS AUTOMATED CLEARING SERVICES). PLEASE PRINT YOUR BANK/BUILDING SOCIETY ACCOUNT INFORMATION IN THE SPACES PROVIDED BELOW. IT IS ESSENTIAL THAT THE INFORMATION SUPPLIED IS ACCURATELY WRITTEN IN BLOCK CAPITALS. THE DETAILS ARE OBTAINED FROM YOUR CHEQUE BOOK.

SHOULD YOU CHANGE YOUR BANK/BUILDING SOCIETY DETAILS AT A LATER DATE, YOU MUST NOTIFY US IMMEDIATELY.

FULL NAME OF ACCOUNT HOLDER .....

BANK OR BUILDING SOCIETY NAME;

.....

BRANCH ADDRESS .....

.....

ACCOUNT NO. (8 NUMBERS) .....

(OR BUILDING SOCIETY REFERENCE/ROLL NUMBER IF APPLICABLE)

SORT CODE NO. (6 NUMBERS) .....

**Declaration;**

I confirm that I wish to have payments sent to my bank/building society account as detailed above and that I have checked these to be correct.

Full name .....Signed.....

**MIKE RIGLIN NURSING PRE-EMPLOYMENT MEDICAL HEALTH QUESTIONNAIRE (Private & Confidential)**

Please complete all sections

**INTRODUCTION**

All information provided by applicants in the completion of this questionnaire will be treated in the *strictest confidence*. We will assess these answers to determine your fitness for your proposed job.

Please answer all questions fully and accurately so that your fitness for employment can be assessed objectively.

Ticking 'yes' to any question does not mean you will be regarded as unfit for the purpose you have applied for. We do want to ensure, however that your working conditions would not aggravate any present condition.

Section 5 contains the Declaration, which you must sign to confirm that the information you have provided is both complete and correct. In doing so, you should recognise that any failure to disclose all relevant information concerning your health might result in termination of your employment with Mike Riglin Nursing.

**Section 1: (G.P. DETAILS)**

**NAME OF GENERAL PRACTITIONER**.....

**ADDRESS** .....

.....

**TELEPHONE NUMBER** .....

**Section 2: (History of Accidents & Illnesses)**

Please read the following questions carefully and give a 'yes' or 'no' answer. If the answer to any question is 'yes' or you are not sure, please provide details and dates where known. Space is provided at the end of the questionnaire for any additional information, which you may feel is relevant.

1. Have you ever been denied employment or been dismissed or retired from a job on health grounds? Yes/No
2. Have you had any major operations? Yes/No  
If 'yes' please supply details .....
3. Have you ever had an illness or accident requiring admission to hospital or treatment as an outpatient?  
Yes/No  
If 'Yes' please supply details .....
4. Have you had a chest X-Ray in the last five years? Yes/No  
If 'Yes' please supply details .....

5. Do you suffer now or have you suffered in the past from any of the following conditions?

- |                              |        |
|------------------------------|--------|
| (a) Heart problems           | Yes/No |
| (b) Diabetes                 | Yes/No |
| (c) Cancer                   | Yes/No |
| (d) Other Hereditary Illness | Yes/No |

6. Are you at present taking any medication, either regularly or occasionally? Yes/No  
(e.g. tablets, inhalers, medicines, creams etc.)

7. Are you at present having any treatment from your G.P., Hospital Doctor or other Physician? Yes/No  
If 'Yes' please supply details .....

8. Are you on a waiting list for hospital admission? Yes/No  
If 'Yes' please supply details .....

### SECTION 3: (History of Specific Ailments & Disabilities)

Do you have, or have ever suffered from any of the following conditions?

- |   |        |
|---|--------|
| 9. Fainting attacks or giddiness?   | Yes/No |
| 10. Epilepsy?   | Yes/No |
| 11. Mental Illness  | Yes/No |
| 12. Stress related problems?  | Yes/No |
| 13. Anxiety or depression requiring visits to G.P, Counsellor or Therapist? | Yes/No |
| 14. Headaches or Migraines?   | Yes/No |
| 15. Post-viral illness or ME?   | Yes/No |
| 16. Ear problems or deafness?   | Yes/No |
| 17. Eye problems or deflection vision                                       | Yes/No |
| 18. Do you wear glasses or contact lenses                                   | Yes/No |
| 19. Recurring chest disease?  | Yes/No |
| 20. Asthma?   | Yes/No |
| 21. Allergies /Hayfever?  | Yes/No |
| 22. Chest Pain?   | Yes/No |
| 23. Shortness of breath at rest?  | Yes/No |
| 24. Heart Problems?   | Yes/No |
| 25. Any blood disorder?   | Yes/No |
| 26. High blood pressure requiring treatment or monitoring?                  | Yes/No |
| 27. Varicose veins?   | Yes/No |
| 28. Back pain and/or back problems?   | Yes/No |
| 29. Muscle of joint pain?   | Yes/No |
| 30. Work related upper limb disorder or RSI?                                | Yes/No |
| 31. Diabetes requiring insulin or tablets?                                  | Yes/No |
| 32. Kidney or Bladder problems?   | Yes/No |
| 33. Bowel problems?   | Yes/No |
| 34. Stomach or digestive problems including eating disorders?               | Yes/No |
| 35. Yellow jaundice?  | Yes/No |

**Do you have any physical disabilities that affect you in any of the following situations or environments?**

- 1. Standing Yes/No
- 2. Walking Yes/No
- 3. Stair climbing Yes/No
- 4. Lifting Yes/No
- 5. Use of hands Yes/No

**SECTION 4: GENERAL LIFESTYLE**

- 1. Do you smoke? Yes/No  
If 'Yes' how many per day?  
.....
- 2. Do you consume alcoholic drinks? Yes/No
- 3. If 'Yes' please estimate your average weekly consumption in units .....  
(definition of one unit of alcohol:  
half a pint of ordinary strength beer, lager or cider,  
One small glass of sherry,  
One small glass of wine,  
One single measure of spirits
- 4. Have you ever had an alcohol or drug dependency problem in the past? Yes/No

**SECTION 5: ADDITIONAL MEDICAL INFORMATION**

Have you been vaccinated against the following, please circle yes or no.

VACCINATION NAME	VACCINATED/SCAR/HISTORY DETAIL i.e. childhood	DATE/ DATE GIVEN
BCG (T.B.)	YES/NO	
HEPATITIS B	YES/NO	
VARICELLA (CHICKEN POX)	YES/NO	
RUBELLA	YES/NO	
MMR (MEASLES, MUMPS, RUBELLA)	YES/NO	

Note; Documented records of vaccination status or confirmation of immunity must be present at interview, or confirmation that you have requested the information.

Hepatitis B vaccination is advisable for your own safety, if you have not already been vaccinated you should contact your GP surgery for this treatment as soon as possible. You may be referred to a private health service provider for this vaccination.

**SECTION 6: DECLARATION**

**ADDITIONAL INFORMATION;**

I HEREBY CONFIRM THAT THE ANSWERS I HAVE PROVIDED TO THE ABOVE QUESTIONS ARE ACCURATE TO THE BEST OF MY KNOWLEDGE AND I HAVE NOT WITHHELD ANY RELEVANT INFORMATION THAT MAY HAVE A BEARING ON THE STATE OF MY HEALTH.

I ALSO HEREBY GIVE CONSENT TO THE MIKE RIGLIN NURSING MEDICAL ADVISOR TO OBTAIN ANY FURTHER MEDICAL DETAILS FROM MY G.P., RELEVANT TO THIS APPLICATION, IF NEEDED. FURTHERMORE, I ACCEPT THAT THE DISCLOSURE OF ANY RELEVANT MEDICAL INFORMATION CONCEALED WITH THE PURPOSE OF OBTAINING EMPLOYMENT WITH MIKE RIGLIN NURSING WILL CONSTITUTE GROUNDS FOR TERMINATING ANY EMPLOYMENT.

YOUR SIGNATURE WILL BE TAKEN AS:-

YOUR UNDERSTANDING THAT ANY OFFER IS SUBJECT TO THE RECEIPT OF A MINIMUM OF TWO SATISFACTORY REFERENCES AND YOUR PERMISSION TO CONTACT YOUR REFEREES AND PREVIOUS EMPLOYERS TO OBTAIN REFERENCES.

YOUR UNDERSTANDING THAT ANY OFFER IS SUBJECT TO CLEARANCE OF A CRIMINAL RECORDS BUREAU DISCLOSURE

***Rehabilitation of Offenders Act; Because of the nature of the work for which you are applying, section 4 (2), and further orders made by the Secretary of State under the provision of this section of the Rehabilitation of Offenders Act (1974) (Exceptions) Order 1975 applies. Applicants are therefore required to give information about convictions which for other purposes are "spent" under the provisions of the Act. Any information given will be completely confidential and will be considered only in relation for positions to which the order applies.***

SIGNATURE OF APPLICANT ..... DATE.....

THANK YOU FOR COMPLETING THIS FORM

MIKE RIGLIN NURSING IS REGISTERED WITH THE CARE QUALITY COMMISSION FOR BOTH DOMICILIARY AND NURSES AGENCIES

REVIEWED APRIL 2015