PROXYCARE
Staffing Solutions

APPLICATION FORM

Please complete all sections using CAPITAL LETTERS and return with required documents

POSITION APPLIED FOR	DATE OF APPLICATION

PROFESSIONAL REGISTRATION DETAILS

Profession:	**Professional Registration No:**

Fit to Practice: Are there any Restrictions or have you ever been subject to a Restriction or Suspension by your Professional Body? Yes ☐ No ☐

If YES, please specify:

PERSONAL DETAILS

Surname:	Forenames:	**Preferred Name:**
Title:	Date of Birth:	Previous Names:
Home Tel:	Mobile:	Work Tel:

Email Address:	National Insurance Number:

Present Address:	Postcode:	

Driving Licence: Yes ☐ No ☐	Type:	How do you usually travel to work	
Nationality:	Passport No:	Visa type:	Expiry date:

Are there any restrictions on your Right to Work / work permit in the UK? Yes ☐ No ☐

If YES, please provide a copy of the Work Permit / Certificate of Sponsorship ? Yes ☐ No ☐

NEXT OF KIN DETAILS (in the case of emergency who should we contact?)

Surname:	Forename:	Relationship:
Address:		Mobile:
	Postcode:	Home Tel:

EDUCATION & TRAINING / QUALIFICATIONS - if on your CV please advise "See CV"

Original documents as proof of qualification will be required at the interview

School/College/University	Qualification	Date of Qualification

EMPLOYMENT HISTORY (please continue on a separate sheet if required) - if on your CV please advise "See CV"

Please give details of your past 5 years of continuous work history including the reasons for any breaks in employment (most recent first)

From	To	Employer's Name and Address	Job Title / Specialty	Telephone	Reason for leaving

Have you ever been subject to Disciplinary Action, Suspension or Dismissal? Yes ☐ No ☐

If YES, please specify:

Have you worked for agency before? Yes ☐ No ☐

What is your current grade and your salary expectations?

REFERENCES

In line with framework requirements Proxycare are required to obtain references covering a 5-year work history. Start with your present or most recent employer, they must be working at a more senior grade/level or your immediate line manager and you must have worked for that person for a period of not less than three months duration.

1. Name:	Position:	Tel:
Fax no:	Email Address:	Mobile no:
Work Address:		Postcode:
Dates of employment	From:	To:
In what capacity and for how long has this person known you?		

2. Name:	Position:	Tel:
Fax no:	Email Address:	Mobile no:
Work Address:		Postcode:
Dates of employment	From:	To:
In what capacity and for how long has this person known you?		

3. Name:	Position:	Tel:
Fax no:	Email Address:	Mobile no:
Work Address:		Postcode:
Dates of employment	From:	To:
In what capacity and for how long has this person known you?		

WORK PREFERENCE - please indicate preferred days (tick where appropriate)

When are you available?	From:		To:	
Are you interested in:	☐ Long Term	☐ Short Term	☐ Part Time	☐ Others
	☐ Mornings	☐ Afternoons	☐ Nights	☐ Weekends

Mon ☐	Tues ☐	Wed ☐	Thurs ☐	Fri ☐	Weekends ☐

What is your closest main line or tube station:	How far would you travel? hrs/miles	Do you own a car? Yes ☐ No ☐
Do you have any commitments that reduce your flexibility to work?	Yes ☐	No ☐
If YES, please state:		

BANK DETAILS - Please supply evidence that the account is in your name/Ltd company name, e.g. bank statement (within last 3 months)

Name of Bank:		National Insurance Number:
Bank Address:		
		Postcode:
Account holder:	Sort code:	Account No:
P45 enclosed Yes ☐ No ☐		P46 required Yes ☐ No ☐

LANGUAGE SKILLS

		WRITTEN			SPOKEN		
		Fluent	Good	Fair	Fluent	Good	Fair
Are you competent in understanding and using both written and oral English?	Yes ☐ No ☐						
Do you speak any additional languages?	Yes ☐ No ☐						
If YES, please advise:							

Please include any further information that you feel is relevant to this application on a separate sheet.

PLEASE ENSURE YOU SIGN AND COMPLETE THE FOLLOWING SECTIONS

DECLARATION OF HEALTH (all questions must be answered and declaration signed and dated)

Do you have any health conditions or disability that might impair your abilities to cover the roles you are being employed for? **If YES, please advise of details:**	Yes ☐	No ☐
Do you suffer or have suffered from Mental health or stress related illness? **If YES, please advise of details:**	Yes ☐	No ☐
Do you suffer or have suffered from a Drug or Alcohol related problem? **If YES, please advise of details:**	Yes ☐	No ☐
Do you ordinarily enjoy good health? **If NO, please advise of details:**	Yes ☐	No ☐
Have you ever left work for health reasons? **If YES, please advise of details:**	Yes ☐	No ☐
Are you returning to work after having been signed off? **If YES, you must provide evidence of a 'fitness to work' certificate from your GP. We cannot place you in assignments if this is not provided as it could pose a health risk and jeopardise insurance.**	Yes ☐	No ☐
Workers who have travelled to countries which have been affected by Ebola may undergo additional OH Risk Assessments. Have you travelled outside of the UK in the last 21 days? **If YES, please advise of location:**	Yes ☐	No ☐

I declare that I have answered the above questions fully and honestly. I am not aware of any physical or mental disability which will affect my working capacity. I consent to Proxycare disclosing medical data to clients when required.

Print Name:	**Signed:**	**Date:**

REHABILITATION OF OFFENDERS ACT (all questions must be answered and declaration signed and dated)

Because of the nature of the work for which you are applying, the provisions of Section 4 (2) and further Orders made by the Secretary of State under the provisions of this section of the Rehabilitation of Offenders Act (1974) (exceptions) Order 1975 are not applicable, therefore applicants are 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.

Do you have any convictions or cautions (excluding youth cautions, reprimands and warnings) that are not 'protected' as defined by the Ministry of justice? **If YES, please give details:**	Yes ☐	No ☐	
Do you have any criminal proceedings pending or unspent conditional cautions or convictions under the Rehabilitation of Offenders Act 1974? **If YES, please give details:**	Yes ☐	No ☐	
Do you have an original DBS certificate with update service? **If YES, please supply a copy of your current DBS certificate**.	Yes ☐	No ☐	Date of Issue:

It is a condition of proceeding with your application that Proxycare initiate an "Enhanced" DBS Check annually. However, should you hold a DBS which is registered with the Update Service, Proxycare must view the original certificate.
Convictions and any other criminal record information obtained through the DBS checking service will not necessarily be a bar to employment opportunities. All circumstances will be taken into account. However, any inconsistencies when compared with the information given on this application may invalidate your application. A full copy of the DBS check will be forwarded to you directly by the DBS. A summary of results are provided to Proxycare.

I hereby confirm my understanding that a copy of DBS Check will be retained by Proxycare. Should I have a registered DBS, I understand by signing below I authorise Proxycare to check the Update Service Website monthly/quarterly/annually as applicable. The copy of my DBS is retained in order to produce to third party audit organisations for compliance and audit purposes. Proxycare may utilise data from the DBS Disclosure when sourcing work opportunities, in accordance with the DBS code of practice. All sensitive information will be retained in a secure place, and in full compliance with the Data Protection Act 1998.

Print Name:	**Signed:**	**Date:**

WORKING TIME DIRECTIVE

In compliance with the implementation of the Working Time Regulations, the Employment Business recommends that working time should not exceed 48 hours per week (averaged over 17 weeks). Temporary Workers may choose to opt out of the Working Time Directive if they wish, to be available for work or more that 48 hours per week. Should you wish to waive this right, please indicate this preference by a circle around your choice below:

I wish to opt out ☐ **I do not wish to opt out** ☐

(You can change your chosen option by giving three months' notice in writing to Proxycare).

Print Name:	**Signed:**	**Date:**

CONFIDENTIALITY

I hereby declare that at no time will I divulge to any person, nor use for my own or any other person's benefit, any confidential information in relation to the Client or Proxycare or in relation to any of their employees, business affairs, transactions or finances which I may acquire during the term of my agreement with the Proxycare under the Terms of Engagement. I declare that by signing this form I agree to abide by the contents therein.

Print Name:	**Signed:**	**Date:**

DECLARATIONS (all questions must be answered and declaration signed and dated)

I declare that the information provided on this application form are correct to the best of my knowledge and belief. I understand that if I withhold any relevant information or I have given any information which is false or misleading this may lead to my application being rejected, or if already appointed, to my dismissal. I understand that information given on this form will be used for registration purposes under the Data Protection Act. I also authorise Proxycare to disclose any convictions declared above to any potential employers in accordance with the CRB Code of Practice and the Rehabilitation of Offenders Act. (Please complete where applicable and sign below). **I also understand that by accepting assignments from Proxycare, I am accepting the terms of engagement and the company's policies and procedures.** I understand that my appointment is subject to the receipt of two satisfactory references and Enhanced DBS Check.

Equal Opportunities Declaration I confirm that I have read and understand the equal opportunities policy and procedures to follow	Yes ☐	No ☐	Not Applicable ☐
Health & Safety Declaration I confirm that I have read and understand my health and safety responsibilities.	Yes ☐	No ☐	Not Applicable ☐
Permanent Employment Declaration I confirm that Proxycare may act on my behalf in identifying suitable permanent positions	Yes ☐	No ☐	Not Applicable ☐
Payment deductions for PAYE workers I confirm that Proxycare (as per their standard terms of engagement) will deduct directly from my weekly pay PAYE, National Insurance contributions and any other sums that may be due.	Yes ☐	No ☐	Not Applicable ☐

Print Name:	**Signed:**	**Date:**

MANDATORY TRAINING – must be completed annually and in line with Mandatory & Statutory Training ('Skills for Health' aligned CSFT)

Have you recently attended or completed any Practical and/or Online Courses? If YES, please provide certification	Yes ☐ No ☐

I understand that all Mandatory training must be completed annually, and the training modules may be subject to change. I confirm that I will complete all Practical and Online training as required.

Print Name:	**Signed:**	**Date:**

ORIGINAL DOCUMENT CHECKLIST - Copies of the following documents are required before we can place you in an assignment/locum work.

This is a contractual requirement of the National Framework Agreement for the Supply of Agency staff to the NHS. Please note in addition to the list below you will be required to complete further compliance requirements and to attend an interview to verify original documents.

Evidence of:	**Evidence Required:**	**Enclosed YES / NO**
Completed Registration form & Updated Curriculum Vitae	**CV (Word Format)** covering all work history from Schooling. Any gaps 3 weeks or more must be explained on CV.	Yes ☐ No ☐
Right to work in UK	Originals: Passport/Visa/ BRP/Home Office letter if applicable	Yes ☐ No ☐
Proofs of Address & Proof of NI Number	2 x Proofs of Address dated within last 3 months & Proof of NI number.	Yes ☐ No ☐
Professional Registration	HCPC / NMC Certificate, Proof of payment/renewal to professional body	Yes ☐ No ☐
Qualifications / Training Certificates inc Mandatory Training	Originals - Diploma/Degree/NVQ – Any other training Certificates	Yes ☐ No ☐
Two colour passport sized photographs	For ID badge purposes	Yes ☐ No ☐
Most recent DBS registered with update service	Original - DBS certificate & proof of DBS registered with update service	Yes ☐ No ☐
Completed Health Questionnaire & Medical Vaccinations	Hep B, TB, MMR (Measles, Mumps & Rubella) & Varicella. NB Varicella can be self-declared if you have had Chicken Pox.	Yes ☐ No ☐

I understand that any personal data held by Proxycare is liable to be inspected by 3rd parties/NHS approved procurement partners and our Clients as part of their audit procedures and may be passed on to the accounting services for administration of payroll.

Print Name:	**Signed:**	**Date:**

I understand that I will be required to provide Proxycare, as and when requested, Payslips and corresponding bank statements showing net pay figures received from Umbrella Companies. Proof is required to ensure that appropriate PAYE & NI deductions are made in line with HMRC regulations and are part of the Framework external auditor requirements where applicable.

Print Name:	**Signed:**	**Date:**

GDPR – GENERAL DATA PROTECTION REGULATIONS

The consent I give to the Company will last for as long as necessary for the purpose it was collected, and once the Company no longer need it, it will be deleted or anonymised. I am aware that I have the right to withdraw my consent at any time by writing to Proxycare.
I also consent to the Proxycare processing my personal data with third parties including Authorities, their representatives, Framework Body and/or any relevant framework providers, Umbrella payroll services, external auditors where necessary for the purposes of internal/external audits and investigations carried out on the Proxycare to ensure that the Proxycare is complying with all relevant laws and obligations.

Print Name:	**Signed:**	**Date:**

RIGHT TO WORK CHECKS - I confirm that I agree that Proxycare can carry out any Right to Work Checks including online as deemed necessary.

Print Name:	**Signed:**	**Date:**

COMPLIANCE REQUIREMENTS - **Proxycare are required to carry out full compliance checks for all candidates annually.** In most cases the compliance requirements are limited to the Disclosure & Barring, Occupational Health checking, mandatory training and appraisal as well as the provision of original documentation at interview, however Proxycare request that the candidate contribute to the full cost of compliance. These compliance costs will be deducted over 3 weekly payment terms following the candidates' initial commencement date.

Print Name:	**Signed:**	**Date:**

CONTRACT OF ENGAGEMENT AND HANDBOOK DECLARATION - **I confirm that I have received and read Proxycare Contract of Engagement and Candidate Handbook, where I have understood the terms and conditions, policies, procedures and guidance given.**

Print Name:	**Signed:**	**Date:**

INDEMNITY INSURANCE - All Qualified Health Professionals are required to hold individual Indemnity Insurance cover which is appropriate to their role and scope of practice and its risks as a mandatory requirement of the NMC Code / Registration body (please provide evidence of this).

Print Name:	**Signed:**	**Date:**

If you do not hold Professional Indemnity Insurance, please sign the following statement. I do not currently hold Medical Insurance.

Print Name:	**Signed:**	**Date:**

PERFORMANCE APPRAISAL

We need to have a record of your arrangements for annual appraisal by an appropriate practitioner. Can you please provide the date of your last appraisal and the date of your next appraisal along with details of your Appraiser

Name of Appraiser:	Contact Details:	Date of Last Appraisal:	Date of next Appraisal:

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Disclosure & Barring Service Check Application

Surname:	Forenames:	Middle Name:
Title:	Date of Birth:	National Insurance Number:
Marital Status:	Date of Marriage:	Maiden Name:
Previous Names:	From:	To:
Town/City of Birth:	Country of Birth:	Nationality at Birth:

Current Nationality:	Passport No:	Visa details (if applicable):	Expiry date:
Birth Certificate No:		Home Office Letter Ref:	

Are you currently subject to any criminal proceedings, convictions or cautions: Yes ☐ No ☐

If yes, please specify:

You must provide all the addresses where you have lived in the last 5 years. There must be no gaps in dates, however overlapping dates are acceptable. **All fields must be completed for each address**

Current Address	
Town / City	**County**
Post Code	**Country**
From	**To**

Previous Address	
Town / City	**County**
Post Code	**Country**
From	**To**

Previous Address	
Town / City	**County**
Post Code	**Country**
From	**To**

Previous Address	
Town / City	**County**
Post Code	**Country**
From	**To**

The Care Standards Act 2000 requires that a check be made on you with the Disclosure & Barring Service. Failure to agree to apply for a disclosure to the Disclosure & Barring Service will result in Proxycare being unable to accept your application. I confirm that the above information is true and I agree for Proxycare to apply for a DBS Check on my behalf using the above information. I consent to share the details of the DBS check with the third party in order to secure work on my behalf.

Print Name:	**Signed:**	**Date:**

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DECLARATIONS & INDUCTION CHECKLIST

I can confirm that I have received, read through and understood all of the following:

	TICK BOX	DATE
Staff Handbook received	☐	
Contract of engagement received	☐	
GDPR Policy received	☐	
Confidentiality: Data protection in the workplace explained	☐	
Dress code explained	☐	
Uniform received	☐	
ID badge received	☐	
Providing your availability	☐	
Timesheet submission and completion explained	☐	
Confirmation of bookings and cancellation of assignments procedure	☐	
Emergency out of hours contact explained	☐	
48hours opt out explained	☐	
Rates of pay, method of payment explained	☐	
Holiday pay entitlement explained	☐	
Payroll explained	☐	
Supervision and disciplinary procedure	☐	
Training and refresher training explained	☐	
Appraisals and annual references explained	☐	

APPLICANT SIGN OFF	AGENCY SIGN OFF
NAME:	NAME:
ROLE APPLIED FOR:	POSITION:
SIGNATURE:	SIGNATURE:
DATE:	DATE:

Digital Signature