HHG MEDICAL

Job Application Form

Please complete all sections of this application form and other documents clearly in **CAPITAL LETTERS** and **BLACK INK**

1. Position you are applying for.

Qualified Nurse RMN ☐ RGN ☐ RLDN ☐

Medical Doctor ☐
Specialisation:……..

Applied Healthcare Professional. ☐
Specialisation : (e.g Radiographer, Biochemist), ……..

HCA/ Support Worker ☐ Hygienist ☐

2. Personal Details

Surname :	**First Name(s):**
Mr/Mrs/Miss (please Circle)	
Address :	
Post Code :	**Mobile No.**
Email Address:	
Do you have a driving licence ? Yes ☐ No. ☐	

3 Rehabilitation of offenders Act 1974.

Have you been convicted of a criminal offence in the UK?

No ☐

Yes ☐ A risk assessment of your conviction will conducted upon your application been successful.

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4. Please tick the documents you intend to use to support your application

(i)	2 passport size photos	☐
(ii)	Right to work documents	☐
(iii)	Enhanced DBS (at least within 1 year old)	☐
(iv)	DBS update reference No.	☐
(v)	Willing to apply for a new DBS	☐
(vi)	Bank account details	☐
(vii)	Mandatory training Certificates.(valid)	☐
(viii)	MAPA/PMVA certificates/Blue Card(valid)	☐

5. Right to work In UK Documents

Do you have any restrictions on your right to work in the UK? Yes ☐ No ☐

Under Section 8 of the immigration Act, we are required to check all employees are eligible to work in the UK. Please confirm that, if you are registered to with us, which of the documents below would you be prepared to submit and allow us to make copies(**Please indicate with a tick ✓**)

(a) **Proof of ID . If you are a UK citizen any document without a photo must be submitted with a government issued ID eg driving licence or passport(1 document).**

UK Birth certificate with names of your parent . ☐
Home Office issued work permit visa/Biometric Residency permit ☐
Home Office Settled Status documents for EU citizens. ☐
UK passport ☐
Home Office Application Registration Card permitting employment ☐
Home Office issued letter indicating permission for indefinite stay in the UK. ☐

Please get Home office Share Code from https://www.gov.uk/view-prove-immigration-status and email it to info@hhg-online .co.uk

(b) Proof of National insurance (1 document)

HMRC National Insurance Letter or Benefits letter ☐
P45/P60 from previous employer/Payslip ☐

(c) Proof of address (2 documents from the list below)

Bank statement ☐
Driving licence ☐
Utility bill(Not Mobile phone) ☐
Any government letter showing your address ☐

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6. Disability Discrimination Act 1995

The Disability Discrimination Act 1995 protects people with disabilities from unlawful discrimination.

Do you consider yourself disabled? Yes ☐ No. ☐

If yes, please tell us what adjustments would be needed to ensure you are comfortable during the interview.

7. Education History

University/College/ High School	Date in Education From	To	Qualification Obtained

8. Current Employment

Name of employer	Job Title	Notice Period Required

Current Duties and responsibilities :

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9. Employment History

Dates From	to	Name & address of Employer	Job Title	Main Duties

Also Submit you CV to include all jobs since you left high school if any

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10. References

Do you have at least six (6) months experience working in the health care sector?

Yes ☐ No. ☐

If yes the please provide two references.

Reference 1.	**Reference 2**
Name :	Name :
Address :	Address :
Post code :	Post code :
Email :	Email :
Mobile :	Mobile :

11. Declaration

(Please read carefully before signing the application)

I agree that any offer of employment is subject to satisfactory references, Occupational Health checks (if required) and a probationary period.

I confirm that the information supplied by me on this form and all documents required, with this application are complete and correct and that any untrue or misleading information will give my employer the right to terminate any employment contract offered.

Sign here : …….. Date: ……

For office use only

Date received ☐ Reference 1 checked ☐ Reference 2 checked ☐

DBS Checked ☐ Driving licence checked. ☐ Right to work documents checked ☐

Interview date : ☐

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OCCUPATIONAL HEALTH FORM.

PLEASE COMPLETE THE FORM GIVE YOUR GP TO COMPLETE THEIR ASSESSMENTS.

SECTION 1 Personal details.

Title : Mr☐ Miss☐ Ms ☐ Mrs ☐

First Name :…….

Second Name :……..

Expected Start Date: …../……/……...(dd/mm/yyyy)

Home address:……..

……...

Post Code : ……..

Job Title (Please tick)

HCA :☐ Email:……..

SUPPORT WORKER :☐ Mobile:……

QUALIFIED NURSE :☐

SECTION 2

What are the specific requirements of the job? (tick the appropriate boxes)

☐**No patient contact** *e.g. clerical post in non-clinical area.*

☐**Direct patient contact (non clinical)** *i.e. respiratory contact/ manoeuvring patients.*

☐**Direct patient contact (clinical)** e.g. *involved in providing patient care.*

☐**Exposure prone procedures (EPP)** eg injecting ,suturing or dressing individual's wounds.

SECTION *3*

What are the specific requirements of the job which require health surveillance? Please tick if any of the following would pose a risk to your health during your work.

☐Display Screen Equipment user

☐Noise (> than 80dBa TWA)

☐Respiratory sensitisers, specify sensitising agent:…….

☐ Skin sensitisers, specify: latex or other sensitising agent:……

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☐ Hand Arm Vibration, specify vibration tool:……

☐ Other - specify agent and type of surveillance:……

SECTION 4

DISABILITY

1. Do you consider yourself disabled: Yes ☐ No☐

If yes please describe your physical challenges.

……

Do you suffer from any mental illness? Yes ☐ No.☐

If yes please describe your illness;

……

2. Do you have any known allergies? Yes ☐ No ☐

If yes, please specify details:

……

3. Please answer the following declaration:

I am not aware ☐ OR I am aware ☐

of any health conditions or disability which might impair my ability to undertake effectively the duties of the position which I have been offered and which might require specialist adjustment to my work, or at my place of work.

4. Please give details of any adjustments or assistance required to help you to do the job:

……

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SECTION 4 BIOSAFETY DISCLOSURE

Do you already work for the NHS and have already undergone occupational health checks? Yes ☐ No.☐

If yes please provide evidence. If no please complete all the other sections below.

(a)TUBERCULOSIS (TB) STATUS

1. Have you lived or worked for 4 weeks or more outside the UK in the last 5 years? Yes☐ No ☐

   If yes, please list the countries that you have lived in: ……

2. Do you have any of the following:

   A cough which has lasted for more than 3 weeks? Yes ☐ No☐

   Unexplained weight loss? Yes☐ No☐

   Unexplained fever? Yes ☐ No☐

3. Have you had TB or been in recent contact with open TB? Yes☐ No☐

4. Have you had a BCG vaccination in relation to TB? Yes☐ No ☐

   Date: ……

5 Do you have a BCG scar? If yes please state which site e.g. left arm. Yes ☐ No ☐

   Site: ……..

6. Have you ever had a TB skin test e.g. heaf/mantoux? Yes ☐ No☐

   Date: ……..

   Result:……

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(b) IMMUNISATION STATUS

IMMUNISATION STATUS PLEASE COMPLETE THIS SECTION FULLY		YES	NO	YEAR	RESULT
Hepatitis B vaccination	1st dose	☐	☐		
	2nd dose	☐	☐		
	3rd dose	☐	☐		
	Booster	☐	☐		
	Booster	☐	☐		
Measles, mumps, rubella (MMR) vaccination *(please supply documentary evidence)*	1st dose	☐	☐		
	2nd dose	☐	☐		
Covid 19 Vaccinations	1st dose	☐	☐		
	2nd dose	☐	☐		
	Booster 1 dose	☐	☐		

(c) TO BE COMPLETED BY EPP WORKERS ONLY e.g. Nurses and Doctors.(confirm if your role involve EPP from section 2) Please provide a copy of evidence for this part. Those with HIV need to provide proof showing that their viral load is UNDETECTABLE.

Hepatitis B surface antibody blood test (*please enclose copy if available) EPP posts must supply a copy*	☐	☐		
Hepatitis B surface antigen blood test (*please enclose copy if available) EPP posts must supply a copy*	☐	☐		
Hepatitis C antibody blood test (*please enclose copy if available) New EPP posts since 2002 must supply a copy*	☐	☐		
HIV blood test *(please enclose copy if available) New EPP posts since 2008 must supply a copy*	☐	☐		

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SECTION 5 ALLERGIES (LATEX)

Please complete if your job involves contact with latex gloves / products.	**YES**	**NO**
1. Do you believe you have an allergy to latex? If yes, what type of allergic reaction: What latex product(s) caused it:	☐	☐
2. Have you suffered from redness, irritation, or swelling at the site of exposure to latex e.g. gloves, balloons, condoms? If yes, how soon after latex exposure do the symptoms begin:	☐	☐
3. Have you ever noticed any local swelling following medical or dental treatment? If yes, how soon after do the symptoms begin:	☐	☐
4. Are you allergic to any of the following foods: bananas, avocados, raw potatoes, kiwi fruit or chestnuts? If yes, to what:	☐	☐
5. Do you have any other nut or food allergies? If yes, what:	☐	☐
6. Have you ever suffered from a very severe allergic reaction (anaphylaxis)? If yes, what was the cause:	☐	☐
7. Have you suffered from: a) Asthma	☐	☐
b) Eczema e.g. childhood or infancy	☐	☐
c) Dermatitis of hands (redness, soreness, cracking)	☐	☐
8. When exposed to latex either at work or at home or as a patient have you ever had: a) Itchy /watery eyes	☐	☐
b) Sneezing / rhinitis / runny nose	☐	☐
c) Wheezing / tight chest	☐	☐
d) Rashes other than at the site of latex exposure e.g. urticaria (nettle rash)	☐	☐
e) Collapse (anaphylaxis)	☐	☐
9. In your lifetime have you had four or more operations?	☐	☐
10. Does your current work involve frequent glove use?	☐	☐

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If yes, on average how many hours each day are gloves worn?(state hours)	Hours:
On average, how many times a day do you change latex gloves? (state times)	Times:
ADDITIONAL COMMENTS:	

DECLARATION

I declare that the information I have given on this form is true to the best of my knowledge and belief. I understand that if any information is false or has been deliberately omitted, I may be registered and allowed to work in the NHS. In such cases where an opinion on any adjustment is required I will be contacted to discuss my abilities and the recommended adjustments. I understand that Occupational Health department may with my permission:

- Obtain immunisation and screening results from my GP or previous Occupational Health Department or other NHS organisation.

Please tick the box if you consent to the above ☐

I understand that medical details will not be divulged without my permission to any person outside the Occupational Health department of HHG Medical but that an opinion about my fitness to work, including information about my clearance to undertake clinical work, will be given to management,

Print Full Name: ……..

Signature:……
Date:…….

GP'S DETAILS.

Name of your GP: ……..

Address of your GP

……..

Post Code: …… GP's Phone No. ……

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OCCUPATIONAL HEALTH USE ONLY: (To be completed by a qualified medical professional)

Additional details	**Signature & Print**	**Date**
New Health Care Worker? Yes ☐ No ☐		
Appointment required for: ☐ TB clearance ☐EPP clearance ☐ Vaccination/screening, specify: …… ☐ Nurse assessment ☐ Immunisation assessment ☐ Doctor assessment ☐ Eyesight test ☐ Lung function ☐ Audiometry ☐ Hand Arm Vibration ☐ Other (give details): ……..		
Await: ☐ GP reports ☐ Occupational Health notes ☐ Specialist report ☐ Hepatitis B ☐ Hepatitis C ☐ HIV ☐ Other: …….		
Clearance:		
☐ **A** Fit for employment specified		
☐ **B** Fit for employment specified ***and EPP fit***		
☐ **C** Fit for employment specified ***but not EPP fit***		
☐ **D** Fit for employment with adjustment(s):……..		
☐ **E** Currently unfit for employment review:……..		

Please send completed forms back to

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