15 New Fields Business Park
2 Stinsford Road
Poole
Dorset
BH17 0NF
Tel: 01202 665550
Fax: 01202 665568
admin@wna.healthcare
www.wna.healthcare

15 New Fields Business Park
2 Stinsford Road
Poole
Dorset
BH17 0NF
Tel: 01202 665550
Fax: 01202 665568
nursing@hmr.co.uk
www.hmr.co.uk

YOUR APPLICATION PACK

NAME	
POSITION (RGN / RMN / HCA)	
RECOMMENDED BY	
REVIEWED BY SIGNED BY	Maria Alibhai (86E0211E) and ________________________ Maria Alibhai

PRIMARY COMPANY YOU WISH TO JOIN			
WNA	☐	HMR	☐

DATE	

I agree that the information I provide in this application pack can be used by both sister companies: WNA Healthcare and HMR Medical & Nursing Service. The reason for this is to provide me with more opportunity and diversification in the work I can potentially be offered.

SIGNATURE	

THIS APPLICATION PACK MUST BE RETURNED WITHIN 14 DAYS

PLEASE READ BEFORE FILLING OUT APPLICATION PACK

Reviewed: March 2016
Issue 1, Rev 11

When filling out this application pack can you please make sure to fill it in using CAPITAL LETTERS where is possible. This is to help us process your application more efficiently.

At times WNA Healthcare is shortened to **WNA** & HMR Medical & Nursing Service is shortened to **HMR**.

APPLICANT DETAILS

YOUR PERSONAL DETAILS			
TITLE		SURNAME	
FORENAME			
MIDDLE NAME			
MAIDEN NAME			
MARITAL STATUS			
D.O.B.			
ADDRESS			
ADDRESS 2			
TOWN			
COUNTY			
POSTCODE			
LANDLINE PHONE			
MOBILE PHONE			
EMAIL			

NEXT OF KIN DETAILS	
FULL NAME	
RELATIONSHIP	
ADDRESS	
ADDRESS 2	
TOWN	
COUNTY	
POSTCODE	
LANDLINE PHONE	
MOBILE PHONE	
EMAIL	

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NATIONALITY DETAILS

WNA / HMR do not employ any nurse /carer requiring a work permit or with limited leave to remain in the UK.

NATIONALITY		
NATIVE LANGUAGE		
NATIONAL INSURANCE NUMBER		
ELIGIBILITY TO WORK IN UK Tick as appropriate Not applicable for UK citizen	☐	I am eligible to work in the UK and do not require a work permit.
	☐	I am already in possession of a work permit to work in the UK.
	☐	I need to obtain a work permit to work in UK
	☐	Other (please specify below)

OTHER:	
WORK PERMIT EXPIRY DATE:	

NMC DETAILS			
NMC NUMBER		NMC EXPIRY DATE	
NMC PART(s) OF REGISTER		NMC PART(s) EXPIRY DATE	
PROFESSIONAL INDEMNITY INSURANCE UNION			

TRANSPORT DETAILS			
CAR	☐	PUBLIC TRANSPORT	☐

OTHER (Please specify)	

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YOUR EMPLOYMENT HISTORY

*** Please supply details of your full history starting from secondary school to date.*
*** Please explain the gaps in your history.*
*** Comprehensive CV is acceptable provided it lists your full history from secondary school, and details of the month and years.*
*** Please continue on a different sheet if required.*

DATE FROM MM/YY	DATE TO MM/YY	EMPLOYER'S NAME AND ADDRESS	POSITION	REASON FOR LEAVING

YOUR PROFESSIONAL CONDUCT

Have there been any proceedings of medical negligence or professional misconduct against you and have you ever been suspended or dismissed?

Yes ☐ No ☐

If "YES" please supply details:	

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 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 confidential and will be considered only in relation for positions to which the order applies.

Have you at any time been convicted of an offence? Yes ☐ No ☐

If "YES" please supply details:			
NAME :		SIGNATURE:	

YOUR REFERENCE DETAILS

*** Please supply the name and work address of at least 2 professional referees.*

***One must be from your present or most recent employer and must be a senior grade to yourself.*

***2nd needs to be a previous employer unless you have been employed more than 3 years then it must be someone from your current or most recent employer.*

NAME		GRADE		DOB	

1st Reference	
NAME	
POSITION	
ADDRESS	
ADDRESS 2	
TOWN	
COUNTY	
POSTCODE	
PHONE NUMBER	
FAX NUMBER	
EMAIL ADDRESS	

2nd Reference	
NAME	
POSITION	
ADDRESS	
ADDRESS 2	
TOWN	
COUNTY	
POSTCODE	
PHONE NUMBER	
FAX NUMBER	
EMAIL ADDRESS	

YOUR CLINICAL EXPERIENCE

Place an "X" in the relevant experience/ years you have in each field, or leave blank if not applicable.

General Experience	0-12 months	1 year +	General Experience	0-12 months	1 year +
Medicine	☐	☐	Learning Disabilities	☐	☐
Surgical	☐	☐	Domiciliary Care	☐	☐
Mental Health	☐	☐	Nursing Homes	☐	☐
Prisons	☐	☐	Observation Records	☐	☐
HCA Only	**0-12 months**	**1 year +**	**HCA Only**	**0-12 months**	**1 year +**
Urinalysis	☐	☐	Toileting	☐	☐
BM Testing (Diabetes)	☐	☐	Mobility	☐	☐
Personal Hygiene	☐	☐	Nutrition	☐	☐
Others	☐	☐	Record Keeping	☐	☐

Hospital Experience	0-12 months	1 year +	Hospital Experience	0-12 months	1 year +
A & E	☐	☐	Paediatric A&E	☐	☐
Cardiac	☐	☐	Paediatrics	☐	☐
Chemotherapy	☐	☐	Palliative Care	☐	☐
Clinics	☐	☐	PCIU	☐	☐
Community	☐	☐	Plastic Surgery	☐	☐
Coronary Care Unit	☐	☐	Radiology	☐	☐
Diagnostic Imaging X - ray	☐	☐	Recovery	☐	☐
Dialysis	☐	☐	Renal	☐	☐
Elderly Care	☐	☐	SCBU	☐	☐
Endoscopy	☐	☐	Surgical	☐	☐
General wards	☐	☐	Theatres	☐	☐
Gynaecology	☐	☐	Triage	☐	☐
Health Visitor	☐	☐	Urology	☐	☐
High Dependency Unit	☐	☐	NICU	☐	☐
Walk in Centres	☐	☐	Nurse Practitioner	☐	☐
ITU - Intensive Care Unit	☐	☐	Occupational Health	☐	☐
Learning Disabilities	☐	☐	ODP	☐	☐
Medical Health	☐	☐	Oncology	☐	☐
Mental Health	☐	☐	Orthopaedics	☐	☐
Midwifery	☐	☐	Neonatal	☐	☐

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HMR

YOUR PAYE / LTD BANK ACCOUNT DETAILS

We pay wages directly into a bank account.

BANK DETAILS	
ACCOUNT HOLDER NAME	
COMPANY NAME (if applicable)	
NAME OF BANK	
ADDRESS	
ADDRESS 2	
TOWN	
COUNTY	
POSTCODE	
SORT CODE	
ACCOUNT NUMBER	

Read all the following statements carefully and check the box that applies to you.

I wish to be paid through **a Ltd. Company** and enclose details. (You will be paid as P.A.Y.E until you provide all your documentation to WNA/ HMR)	☐	YES
I am **on P.A.Y.E** (Please enclose P45 if we are your main employer	☐	YES

DATE FORM COMPLETED:	23 March 2016

Please note that without the correct details you will not be paid on time and this sheet will be returned back to you.

Office Use:

HCA ☐ NVQ ☐ RGN ☐ RN2 ☐ RMN ☐

Auto Pay Number:	

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YOUR DECLARATION

1.HEALTH

I declare that the answers given within this Declaration of Health on this form are true and complete to the best of my knowledge and belief. I understand that making false statements or failure to declare health problems could lead to removal from WNA /HMR.

SIGNED:		DATE:	23 March 2016

2.TERMS & CONDITION

I confirm that the information given in this application is, to the best of my knowledge, true.

I am permitted to work in the UK.

I understand that my registration is subject to the receipt of at least two satisfactory references and enhanced disclosure form the Disclosures and Barring Service

I undertake to inform WNA/HMR should I be convicted of an offence in the future.

I undertake to inform WNA/HMR immediately if I am engaged through their induction, including the offer of permanent employment following temporary assignment.

I agree to respect the confidentiality of patient and any other information I may have access to, at all the times.

I have read, retained a copy of, and fully understand the attached "Rules for members working in hospitals".

I am clear that WNA/HMR work on a temporary assignment and cannot guarantee any number of hours; they have no responsibility to pay for hours not worked, regardless of the situation.
I have read, understood and agree to the terms and conditions of work for temporary agency worker, of which I have been given a copy.

SIGNED:		DATE:	23 March 2016

3. INDUCTION /INTERVIEW

I have received a copy of the members handbook and can confirm that I am aware that more detailed information on the Policy and Procedure can be obtain directly from WNA /HMR.

SIGNED:		DATE:	23 March 2016

4. WORKING TIME REGULATION

For the purpose of the Working Time Regulations, 1998 (as amended),I consent to work in excess of the average of 48 hours per week. I understand that I may withdraw this consent by giving WNA/HMR not less than one week notice. I understand that my registration with WNA/HMR can be terminated at any time, following unsatisfactory work reports.

SIGNED:		DATE:	23 March 2016

5. BANK DETAILS

I have completed my bank details and confirm they are complete and correct. I hereby understand that any incorrect or incomplete details can result in a delay of my payment.

SIGNED:		DATE:	23 March 2016

6. DATA PROTECTION

I agree that WNA /HMR Limited retains their right to hold this application and any other data required to process it and to pass on to any authorised third party the details held within, also to retain these details for as long as reasonably necessary in accordance with the Data Protection Act.

SIGNED:		DATE:	23 March 2016

AVAILABILITY QUESTIONNAIRE

1. **Where did you hear about us?**

Internet Search	☐	Job Centre	☐
Social Media	☐	Leaflet	☐
Recommendation	☐	Other (please specify)	☐

2. **Would this be your main job or secondary income?**

Main Job	☐	Secondary Income	☐

3. **Approximately how many shifts would you like to work per week?**

1-2	☐	2-4	☐	4+	☐

4. **What is your preferred shift pattern?**

Early	☐	Late	☐	Night	☐
Long Day	☐	No Preference	☐		

5. **Please detail dates of any time off or planned holiday**

6. **Please choose your preferences for establishments**

	Hospitals	Community	Nursing Homes	Prisons
South	☐	☐	☐	☐
South East	☐	☐	☐	☐
South West	☐	☐	☐	☐
Midlands	☐	☐	☐	☐
North	☐	☐	☐	☐

Other/ specific locations	

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YOUR WORK HEALTH ASSESSMENT GUIDANCE

The Work Health Assessment requirement as laid down by Department of Health is that members must complete a health questionnaire to ensure that they are fit to carry out the duties required. For new starter members WNA/HMR is required to conduct Occupational health pre–employment screening prior to your first placement. This must also be updated on an annual basis.

Please read the following and state if applicable:

1. I am not aware of any health conditions or disability which may impair my ability to undertake effectively the duties of the position which I have been offered.

Yes ☐ No ☐

2. I do have a health condition or disability which might affect my work and which might require special adjustments to my work or at my place of work

Yes ☐ No ☐

If you have answered "YES" please provide details below.

NAME		SIGNATURE	

CONFIDENTIALITY

Information contained within this document is governed by the Data Protection Act 1998. Disclosure of information is only with your informed written consent. Recommendations to your employer will be directed to essential information regarding your health, hazards & risks of your employment, and with due reference to other relevant statutory requirements and professional practice.

OCCUPATIONAL HEALTH SERVICE

We run a full service at our office. Our prices are on average 25% cheaper than the NHS[1]. Appointments are not usually required as our nurse is on-site. We cover vaccinations and blood tests for MMR, Varicella and Hepatitis B. Although we can verify a BCG scar, we do not carry out the tests or vaccination – please contact your local Occupational Health department at Royal Bournemouth Hospital or Christchurch hospital for this. Please be aware that for all hospital work you will need a current and valid Fitness to Work certificate.

[1] Source: Royal Bournemouth hospital Occupational health 2014.

Rules for members working in Hospitals

Please read the rules below for all members going to hospitals:

SOUTHAMPTON GENERAL HOSPITAL

- No blue uniform (white only - nurses)
- Need to sign black book on arriving and leaving (both HCA and RGN)
- Call WNA office immediately if asked to move wards (both HCA and RGN)
- Call WNA office immediately if asked to work hours outside of what you are booked for
- **NURSES ONLY -** EPMA training needs to be completed before first shift:

  All registered temporary nursing staff working for UHS must have e-prescribing experience and/or must undertake *prior* to assignment some additional mandatory training in relation to EPMA via the JAC system.

  For those staff who have already received EPMA training, please note if the individual **does not use their login for 3 months** then the account will become dormant. If this is the case, the "worker" will have to "go through the questions" part of the process for a refresh, they do not have to go through the whole e-learning process again.

- All temporary workers have access to the UHS adverse event reporting system and are able to complete AER's either for incidents involving themselves or any patients they are caring for. The log in for AER system is assigned as "Agency".

Southampton General EPMA Training link is: www.uhs-vle.co.uk/login/index.php

POOLE GENERAL & YEOVIL, SALISBURY & DHUFT COMMUNITY HOSPITALS – NURSES & CARERS

- Need to sign agency book to confirm attendance
- One timesheet per shift and no more than one day per timesheet
- Original copies of timesheets needed for Poole General Hospital in order to be processed by accounts

ROYAL BOURNEMOUTH HOSPITAL – NURSES AND CARERS

- Need to sign agency book to confirm attendance
- Call WNA office if asked to move wards as bank need to release a new reference number for this change

DORCHESTER HOSPITAL – NURSES AND CARERS

- Need to sign agency book to confirm attendance
- Need to call WNA office if asked to work more hours than originally booked for.
- **NURSES ONLY –** EPMA training needs to be completed before you arrive on shift.

EPMA Training link is: http://www.pathologydch.co.uk/nurse_eLearning_Packv2

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