ASHBOURNE
PRIVATE CLIENTS

Licensed by the Care Quality Commission

Application Form

Recruitment & Employment Confederation
APPROVED STANDARDS IN RECRUITMENT

ALL APPLICANTS MUST COMPLETE ALL OF THE RELEVANT SECTIONS OF THIS FORM. INCOMPLETE FORMS WILL BE RETURNED TO YOU AND WILL DELAY YOUR MEMBERSHIP.

Please affix 2 recent Photo's here

Personal Details

Complete all fields

Forenames

Surnames

Present Address

Home Tel. No.

Mobile Tel. No.

Next of Kin

Relationship

Contact Tel. No.

Title Mr Mrs Miss Other

Date of Birth

Nationality

National Ins. No.

Passport No. Exp. Date

Email

Work Tel. No.

Next of Kin Contact Address

Emergency Contact Name and Tel Number if different

How did you hear about us:

Please circle appropriate box

Newspaper Advert (name)

Friend (name)

Internet Advert (name of site)

Other (details)

Qualifications

Reg No.

Exp. Date

Professional Training

Name and address of Training School

Qualification

Start Date

End Date

Other Training

Moving & Handling
Date _____ / ____ / _____

Basic Life Support / CPR
Date _____ / ____ / _____

Infection Control
Date _____ / ____ / _____

Health & Safety
Date _____ / ____ / _____

Fire Safety
Date _____ / ____ / _____

Food Hygiene
Date _____ / ____ / _____

Other Information

Please tick if you have recent experience (UK) in the below areas:

Mental Health | General | Community | Elderly | Paediatrics

Theatre | A & E | ICU | Neonatal | Other ______

Vehicle Access

Do you have access to a car? YES/NO

How many miles are you willing to travel? __________

Education

Please give details of your most recent education not stated before

Name & Address of School/ College/ University

Course name

Start Date

Qualification Achieved

End Date

International English Language Testing (IELTS)

Non EU Applicants Only

Name & Address of School/ College

Grades Achieved

Completion Date

Employment

Please give details of your most recent / current employment first including agencies. Employment gaps must be explained. 10 Years work history is required, please attach a separate sheet if necessary.

Name & Address of Employer

Position Held

Start Date

Speciality

End Date

Name & Address of Employer

Position Held

Start Date

Speciality

End Date

Name & Address of Employer

Position Held

Start Date

Speciality

End Date

Name & Address of Employer

Position Held

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Speciality

End Date

Name & Address of Employer

Position Held

Start Date

Speciality

End Date

Name & Address of Employer

Position Held

Start Date

Speciality

End Date

Referees

Most recent or present two employers- Managers / Band 6 and higher nurses only. This includes agencies. No other referees will be accepted.

Referee 1	Referee 2
Prev. Employers Name	Prev. Employers Name
Their Position	Their Position
Dates worked by YOU	Dates worked by YOU
Work Address Tel.	**Work** Address Tel.

Statement of Criminal Convictions

Because of the nature of the work for which you are applying, the provisions of Section 4(2) of the Rehabilitation of Offenders Act (1974) do not apply by virtue of the Rehabilitations of Offenders Act (1974) (exceptions) (amendments) Order 1986. All 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 treated in confidence and taken into account where the offence is relevant.

Have you ever been convicted in **any** court of **any** offence ? Yes No

Do you have any criminal proceedings pending against you ? Yes No

I agree to inform Ashbourne Healthcare Services immediately if I subject to criminal proceedings

Please sign:______________________________

Details of Convictions or Cautions

Statement of Disciplinary Investigations (Governing Body (e.g. NMC) or Employment)

Have you ever been subject to **any** disciplinary investigations? Yes No

Are you aware of any current circumstances that may lead to future disciplinary hearings / investigations ? Yes No

I agree to inform Ashbourne Healthcare Services immediately if I subject to any Disciplinary investigations:

Please sign:______________________________

If Yes, please give details

Declaration

I certify that the above information is true and that I have received, read and signed a copy of the terms of engagement.

Signed	Date	Print Name

Ashbourne Group Ltd is an equal opportunities employer.

Bank Details

Please supply details of the account into which you would like Ashbourne Healthcare Services to make your weekly payments. Incorrect details, or not supplying details can result in a delay in payment.

Bank / Building Society Name

Bank / Building Society Address

Account Holders Name

Sort Code

Bank Account Number

Building Society Ref. Number

Office Use only

Received by Date

Commencement Date

Interviewed by

Date

Appraisal

Due Date

Due Date

Due Date

Initials

Initials

Initials

Notes

Badge Issued Signed Date

Uniform Issued Signed Date