

REGISTRATION FORM



Please complete all sections using black pen and block capitals

Personal Details

Surname: _____ Forenames: _____ Title: _____

Name you wish to be known by: _____

Address: _____

Country: _____ Post Code: _____

Mobile Phone: _____ Telephone: _____

Email: _____

Date of Birth: / / National Insurance Number: _____

Employment Eligibility

Qualification: _____ Part of the Register: _____

Registration / Pin Number: _____ Exp date: _____

Birth Certificate Number: _____ Nationality: _____

Passport Number: _____ Exp Date: / / Home office letter Ref. _____ Exp / /

What is your work status (if not UK Citizen): _____

Work Permit Held: Yes No Type of Work Permit: _____ Exp / /

Transport

Do you hold a current driving licence: Yes No Do you have your own transport Yes No

Professional Indemnity

Do you have private indemnity insurance: Yes No

Do you belong to a Union Yes No Name of Union: _____

Membership Number: _____ Expiry Date: / /

Professional Indemnity Insurance is required

Marketing Information

How did you hear about Keystone? _____ We offer a finder's fee to a Keystone Member please
give the name _____

Next of Kin

Name:	Relationship:
Telephone Number:	Mobile Number:
Mailing Address:	
Country:	Post Code:
Fax:	Email

Equal Opportunities

Keystone Healthcare adheres to a policy that promotes equal opportunity. To ensure that the policy works effectively please complete the following.

Age: 16-24 25-34 35-44 45-54 55+

Gender: Male Female

Gender Identity (Optional): If you identify as a transsexual or transgender or as intersex please indicate which group you identify with. Transsexual Transgender Intersex

Ethnic Origin:

White: British Irish Other White

Asian: Bangladeshi Indian Pakistani Other Asian

Black: African Caribbean Other Black

Mixed: White and Black Caribbean White and Black African White and Asian
 Other Mixed

Other: Chinese Other Ethnic Groups Prefer not to say

Do you consider yourself to have a disability?

Yes No Prefer not to say

Religion:

Bahia Buddhist Christian Hindu Jain
 Jewish Muslim Sikh Other Prefer not to say
 No Religion

Employment History

Present / Last Employer Name and Address

Postcode:

Telephone Number:

Position Held: Date Started:

Speciality: Date Finished:

Description of Responsibilities

Grade:

Previous Employer Name and Address

Postcode:

Telephone Number:

Position Held: Date Started:

Speciality: Date Finished:

Description of Responsibilities

Grade:

Previous Employer Name and Address

Postcode:

Telephone Number:

Position Held: Date Started:

Speciality: Date Finished:

Description of Responsibilities:

Grade:

Professional References

Keystone Healthcare requires references from your present or most recent employer. By this we mean **actual employers not colleagues.**

Name of referee:	Position:
Company Name:	Start Date: / / End Date: / /
Mailing Address:	
Country:	Post Code:
Telephone Number:	Fax:
Email	Mobile Phone:

Name of referee:	Position:
Company Name:	Start Date: / / End Date: / /
Mailing Address:	
Country:	Post Code:
Telephone Number:	Fax:
Email	Mobile Phone:

Name of referee:	Position:
Company Name:	Start Date: / / End Date: / /
Mailing Address:	
Country:	Post Code:
Telephone Number:	Fax:
Email	Mobile Phone:

Bank Details

Name of Bank / Building Society:

Address:

Account Holder:

Account Number:

Sort Code:

Address of Account Holder:

Post Code:

Payments by BACS transfer will be no more than 14 days following submittal of a completed timesheet into the above account.

Please tick the box that applies below regarding method of payment:

- Limited Company – A copy of your Certificate of Incorporation is required
- PAYE – I have enclosed a P45 / this is my second job so I need a P46*

* Delete as appropriate

Data Protection Consent Form

I hereby consent to privileged information concerning myself being 'processed' by Keystone Healthcare Ltd. I accept that Keystone Healthcare as my employer, are required to process this information in order to perform their duties, rights and obligations. The information gathered will principally be for personnel, administration and payroll purposes.

It is my understanding that the details about me shall include information of sensitive personal nature regarding:

- racial or ethnic origin
- membership or non-membership of a Trade Union
- physical or mental health or condition
- any commission or alleged commission by me of any offence
- any proceedings or the sentence of any court in such proceedings

The term 'processing' includes the obtaining, recording or holding of information or data carrying out any operation or set of operations on the information or data, including organising, altering, retrieving, consulting, using, disclosing, combining, or destroying the information of data.

I have read and understood the above explanation of the processing data relating to myself by Keystone Healthcare and give my consent to the processing of such data.

Print Name:

Signed:

Date: / /

Skills Evaluation Sheet

Evaluation of your skills and level of competency in key areas will help us place you appropriately.

Please use the following codes when completing this skills checklist.

A Anaesthetics **S** Scrub **R** Recovery
THCA Theatre HCA **WHCA** Ward HCA **WN** Ward Nurse

1. Competent in this skill
2. Some experience, would require assistance
3. No experience, comprehensive orientation required.

For Example: **S1**=competent to scrub for this speciality.

Speciality / Procedure	Code	Comments	Dates of experience
Burns			
Cardiac			
Care of the Elderly			
Cell Salvage			
CPV Lines			
Dentals			
Endoscopy			
ENT			
EPI/Spinal Blocks			
Epidural Care			
General Major			
General Minor			
Gynae			
HDU/ITU			
IV Drug Admin			
Laparoscopic			
Maxillo Facial			
Neuro			
Obstetrics			
Ophthalmic			
Orthopaedics Major			
Orthopaedics Minor			
Out Patients			
Paediatrics			
PCA Therapy			
Plastics			
Regional Blocks			
Spinal Surgery			
Surgical Ward			
Thoracic			
Transplant			
Trauma/Acutes			
Urology			
Vascular			
Ward			
X-Ray			

Other – (Please specify):

Declaration:

I acknowledge that it is my responsibility to work within my own clinical/ competence Limits. I understand that I must always adhere to the policies and procedures with regard to health and safety and emergency procedures.

Print Name:

Signed:

Date: / /

Health Statement

(Please complete all details clearly in block capitals and return as soon as possible)

Title:	Surname: (Name should be in full, in print, as appearing on passport)	First Names:
Previous Names:		Date of Birth:
Job Title:	PIN:	Band:
Current Address:		
Permanent Address (if different from above):		
Home Telephone Number:	Work Telephone Number:	Mobile Telephone Number:
Email Address: (Please indicate accurately each character of your email address including full stops, comma etc.)		

Information contained within this document is governed by the Data Protection Act 1998. The information is assessed by our Occupational Health provider, who will approve your fitness to practise. The information will be disclosed for the administration of your application and as part of the process in placing you in temporary or permanent work. Only authorised Keystone Healthcare Group employees and their Occupational Health providers will have access to this information until you have confirmed that you wish your details to be sent to a potential employer or third party in order, to find you work. Please ensure the health statement is completed fully and return it to Keystone Healthcare Group as soon as possible.

Medical History

Do you now, or have you ever, suffered from or received treatment for the following? If your answer to any of these questions is YES please give details in the space overleaf, attach additional paper if required	
1. respiratory symptoms, disorders, or diseases? (including asthma, tuberculosis, bronchitis, allergies)	No / Yes
2. skin symptoms, disorders or diseases? (including eczema, dermatitis, allergies)	No / Yes
3. psychological/psychiatric symptoms, disorders or diseases? (including anxiety, depression, stress, alcohol / drugs / substance misuse or dependence anxiety, episodes of disorientation, agitation, episodes of self-harm, violence, aggression)	No / Yes
4. back or neck symptoms, disorders or diseases?	No / Yes

5. impairment or disability of the upper or lower limbs?	No / Yes
6. uncorrected vision problems? (including recurring eye infections, tunnel vision)	No / Yes
7. hearing problems? (including recurring ear infections, hearing deficits)	No / Yes
8. neurological symptoms, disorders or diseases? (including epilepsy, dizzy spells, blackouts)	No / Yes
9. cardiovascular symptoms, disorders, or diseases? (including high blood pressure, angina, blood disorders or diseases)	No / Yes
10. gastrointestinal symptoms, disorders, or diseases? (including diarrhoea, vomiting, Crohns, Irritable Bowel Syndrome, Diverticulitis, food borne diseases)	No / Yes
11. genito-urinary / gynaecological symptoms, disorders or diseases?	No / Yes
12. endocrine disorders or diseases? (including diabetes)	No / Yes
13. immuno-deficiency symptoms, disorders or diseases?	No / Yes
14. communication (speech) problems?	No / Yes
15. any other health problems not mentioned above?	No / Yes
16. Have you ever had any health problems related to your work?	No / Yes
17. Have you ever claimed a disability pension, industrial injury benefit or been refused life insurance or employment on health grounds?	No / Yes
18. Have you ever been an in-patient or out patient at any hospital, clinic, nursing home or accident or emergency department?	No / Yes
19. Are you currently pregnant, breastfeeding or have you given birth in the last 6 months?	No / Yes
20. Are you presently receiving, or awaiting treatment for a physical or mental health problem?	No / Yes
21. Are you currently taking any prescribed or over the counter medications?	No / Yes
22. Have you lived outside UK for a period of longer than 6 months?	No / Yes
23. Have you had chickenpox as a child or adult? If so at what age?	No / Yes
24. How many days sickness absence have you had during the last 2 years? (please give details below)	
Please give additional details here – continue on a separate sheet if required.	

IMMUNISATION EVIDENCE

NHS Trusts require documentary evidence of immunity to Measles, Mumps, Rubella, Varicella, Tuberculosis and Hepatitis B. For those performing Exposure Prone Procedures, evidence of non-infectivity to Hepatitis C and HIV are required. We therefore request the following information to be forwarded with this health statement. Your GP or previous Occupational Health Unit should be able to assist you with this information.

<p>Rubella:</p> <ul style="list-style-type: none"> • Serological evidence of immunity; OR • Evidence of 2 doses of immunisation 	<p>Measles</p> <ul style="list-style-type: none"> • Serological evidence of immunity; OR • Evidence of 2 doses of immunisation
<p>Varicella:</p> <ul style="list-style-type: none"> • Written declaration of history of disease; OR • Serological evidence of immunity; OR • Evidence of completed course of immunisation 	<p>Mumps</p> <ul style="list-style-type: none"> • Serological evidence of immunity; OR • Evidence of 2 doses of immunisation
<p>Hepatitis B:</p> <ul style="list-style-type: none"> • History of primary immunisation; AND • History of booster immunisation (either in last 5 years); AND • Serological evidence of immunity (Hepatitis B antibody results) (in last 5 years); AND • Serological evidence of Hepatitis B antigen status (annual for those performing Exposure Prone Procedures and non-responders) <p>Hepatitis B e-markers and viral load is required for those with positive hepatitis B antigen status.</p>	<p>Tuberculosis:</p> <ul style="list-style-type: none"> • Occupational Health or GP assessment of BCG scar indicating size greater than 3 mm; OR • Evidence of immunity from mantoux or heaf test results; OR • Evidence of BCG vaccine <p>Chest clinic clearance is required where strong positive mantoux or heaf test results indicate need for further investigation.</p>
<p>Hepatitis C:</p> <ul style="list-style-type: none"> • Serological evidence of non-infectivity (negative Hepatitis C antibody test) <p>Hepatitis C RNA tests are required for those testing positive to Hepatitis C antibodies,</p>	<p>HIV:</p> <ul style="list-style-type: none"> • Serological evidence of non-infectivity (negative HIV antibody test)

DECLARATION

I confirm that I have read this document fully and that all the information given to Keystone Healthcare Group is correct to the best of my knowledge and belief.

I am aware of the need to protect patients and myself and agree to notify Keystone Healthcare Group should my circumstances alter.

I am aware that where I have provided false information as part of this assessment process, Keystone Healthcare Group reserves the right to report this to my employer / placement supervisor.

I consent to the release of my fitness for work and immunity status only to prospective employers.

Signature:

Print Name:

Date:

Rehabilitation Of Offenders Act

Because of the nature of the work for which you are applying, this work is exempt from the provisions of section 4.2 of the Rehabilitation of Offenders Act 1974 (Exemption Order 1975). Applicants are therefore, not entitled to withhold information about convictions which for other purposes are 'spent' under the provisions of the Act and in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action. Any information given will be completely confidential and will be considered only in relation to the application for positions in which the Order applies, and should be entered at the end of any particulars you give in support of your application.

A copy of our policies is available upon request. A criminal record will not necessarily be a bar to obtaining a position. Further guidance can be obtained by reference to the CRB's code of practice, a copy of which is available from our office or on the CRB website www.crb.gov.uk

Have you ever been convicted of a criminal offence? Yes No

Have you completed an enhanced CRB? Yes No

With an Enhanced Disclosure, under Section 4.2 of the Rehabilitation of Offenders Act 1974 (Exemption Order), all previous cautions, warnings and convictions will always be detailed regardless of how long ago they occurred.

Do you have any spent or unspent criminal convictions? Yes No

Any Conviction, caution, reprimand will require a written statement of each and every event and how it does not affect your ability for the role you are applying for.

Have you provided an original Enhanced CRB Disclosure Yes No

Disclosure Number:

Have you supplied additional information with this Registration form for any spent/unspent convictions, cautions or reprimands?

Have you ever been involved in court proceedings? Yes No

PLEASE GIVE ANY ADDITIONAL INFORMATION WHICH YOU MAY THINK MAY BE RELEVANT IN SUPPORT OF YOUR APPLICATION ON A SEPARATE PAGE.

I confirm that the information I have provided in support of this application is complete and true and understand that knowingly to make a false statement could be a criminal offence.

Print Name: _____ Signed: _____ Date: / /

I consent to Keystone Healthcare checking the details I have provided in support of this Registration form against the various data sources in order to verify my identity and process this Registration. These details may be recorded and used to assist other organisations for identity verification purposes such as the CRB, regulatory bodies such as NMC or GSCC.

Print Name: _____ Signed: _____ Date: / /

Keystone Healthcare reserves the right to hold this registration form and any other data required to process your registration (whether in the UK, European Union or elsewhere) and keep for as long as necessary in line with the Data Protection Act.

You must complete the new CRB Disclosure form, even if you have one already with your current employer.