MEDICAL HEALTHCARE PROFESSIONALS

MHP APPLICATION FORM

Post Applied for	NURSE		ODP		HCA		OTHERS	

Which clinical area you wish to work? _____

* Please complete this form in capital letters using black ink.

1. PERSONAL INFORMATION

Mr/Mrs/Miss/Ms			
Surname			
First Name			
Date of Birth			
Address			
	POST CODE		
Telephone no.		Mobile no.	
Email Address			
National Insurance Number			

Do you hold current full UK driving licence	Yes		No		

Next of Kin	Name:	Contact number
	Address:	Relationship to you:

2. EDUCATION AND QUALIFICATIONS

Name of School / College / Universities and Location	Date of attendance		Qualifications/ Study Courses/ Training	Grade
	From: Month/Year	To: Month/Year		

3. EMPLOYMENT HISTORY

Please list most recent employer accounting for any gaps in employment.

DATE FROM	DATE TO	EMPLOYER'S NAME and ADDRESS	POSITION, GRADE AND SPECIALITY	REASON OF LEAVING

4. MEMBERSHIP OF PROFESSIONAL ORGANISATION AND INSTITUTIONS

Name of Professional Body or Organisation	Membership status	Membership Number	Date Attained
NMC			
HCPC			
RCN/UNISON			
Others			

5. CLINICAL AREA

Your expertise clinical areas. Please tick appropriately.

A&E		Midwifery		Radiology	
Cardiac		Neonatal		Recovery	
Clinics		NICU		Renal	
Community		Nursing Home		Dialysis	
Diagnostic x-ray		Occupational Health		SCBU	
Elderly Care		ODP		Surgical	
Endoscopy		Oncology		Theatre	
HDU		Chemotherapy		Triage	
Health Visitor		Orthopaedics		Urology	
Homecare		Paediatric A&E		Walk in centre	
ITU		Paediatrics		Others(Please Specify)	
Learning Disabilities		Palliative			
Medical wards		PICU			
Mental Health		Prison			

FOR THEATRES ONLY								
	Major	Minor		Major	Minor		Major	Minor
ENT			HSDU			General surgery		
DAY Surgery			Thoracic			Neuro surgery		
Eyes			Orthopaedic			Spinal		
Gynaecology			Endoscopy			Renal		
Cardiac			Urology			TRAUMA		
Plastics			Max Fax					
Other Speciality:								

6. WORK REQUIREMENTS

Do you have the right to live and work in the United Kingdom? **Yes** **No**
Do you hold British or EU passport? **Yes** **No**
National Insurance Number?_____
When can you start work?_____
Have you been removed or currently the subject of a fitness to practise investigation proceedings from the register or the licensing or regulatory body in the UK? **Yes** **No**
(if yes, please provide details)

_____
_____
_____
_____

7. REHABILITATION OF OFFENDERS ACT

Have you ever been convicted of a criminal offence? **Yes** **No**
(if yes please provide details)

_____
_____
_____

8. REFERENCE DETAILS

May we contact the referees in relation to this application? **Yes** **No**
Please provide names and work address of at least 2 referees.
Must be from your current employer or most recent employer.

Name and Address	Contact Number and Email	Position Held and Professional Relationship	Date	
			From	To

9. PERSONAL DECLARATION

I confirm that to the best of my knowledge the information is true and correct.

I understand that misleading and inaccurate or untrue statements or knowingly withheld information may result in termination, subject for investigation and may reported to professional bodies.

I understand and agree to respect the confidentiality of every patient and client and other information I may have access.

I understand that I need to act professionally and perform according to my Duties and Responsibility.

For working time directive I consent to work more than 48 hours.

I understand that I need to inform MHP Medical Healthcare Professionals to any changes of my personal details and circumstances or any criminal offense may occur.

Signed: _____
Date: _____

MEDICAL HEALTHCARE PROFESSIONALS

EQUAL OPPORTUNITIES

MHP Medical Healthcare Professionals Ltd has an Equal Opportunities Policy that aims to ensure all employees, agency workers and applicants do not receive less than favourable treatment whether through indirect indiscrimination on the grounds of race, religion, political options, creed, colour or ethnic origin, age, nationality, marital/parental status, sex, sexual orientation or disabilities which are not job related. To enable us monitor the effectiveness of our policy we would ask that all applicants complete the questionnaire provided in the pack. All information provided will be kept confidential and will be used only for statistical monitoring.

PERSONAL DETAILS

SURNAME	
FIRST NAME	
BIRTH DATE	
AGE	
SEX	MALE ( ) FEMALE ( )
MARITAL STATUS	SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED ( ) SEPARATED ( )

ETHINIC ORIGIN

WHITE: BRITISH ( )	ASIAN: BRITISH FILIPINO ( )
WHITE: SCOTTISH ( )	ASIAN: BRITISH CHINESE ( )
WHITE: IRISH ( )	ASIAN: BRITISH BANGLADESHI ( )
WHITE: OTHERS (please specify) ( )	ASIAN: BRITISH PAKISTANI ( )
BLACK: BRITISH AFRICAN ( )	ASIAN: BRITISH INDIAN ( )
BLACK: BRITISH CARIBBEAN ( )	ASIAN: OTHERS (please specify) ( )
BLACK: OTHERS (please specify) _____	ANY OTHER ETHINIC GROUP: _____

RELIGION

CHRISTIAN ( )	NO RELIGION ( )
ISLAM (MUSLIM) ( )	OTHERS: _____
JEWISH ( )	
SIKH ( )	
CHURCH OF ENGLAND ( )	
HINDU ( )	

SEXUAL ORIENTATION

GAY WOMAN ☐	BISEXUAL ☐	OTHER ☐	
GAY MAN ☐	HETEROSEXUAL ☐	PREFER NOT TO SAY ☐	

DISABILITY

Do you consider yourself having a disability? Yes ☐ No ☐

MEDICAL HEALTHCARE PROFESSIONALS

HEALTH DECLARATION

Name of General Practitioner:	
Name of Surgery:	
Address:	Postcode:
Telephone Number:	

Health Questionnaire

General Health Questions	Y	N	Details
Are you in good health?			
Have you lived continuously in the UK for the last 5 years?			
Have you had a BCG vaccination in relation to Tuberculosis?			
Have you ever been treated in the hospital for serious illness or surgery? Please provide dates			
Have you been treated in the hospital for the last 12 months?			
Do any illness/ disability which may affect your work?			
Do you have a cough which has lasted for more than 3 weeks?			
Unexplained weight loss?			
Unexplained fever?			
Have you had tuberculosis or been in recent contact with open TB?			
Have you ever suffered from any mental illness, psychological or psychiatric problems?			
Have you ever had discomfort or pain in the chest or shortness of breath on exercise?			
Do have any difficulty with eyesight?			
Have you suffered from any alcohol or drug related illness?			
Are you having or waiting for treatment or investigation at present?			
Are you receiving any medications from a doctor or on prescription?			

Please provide details of Immunisation and Test History.
A copy of each results must be provided.

		Booster Date
Hepatitis B	Date	1st 2nd 3rd
Hepatitis A	Date	
Hepatitis C	Date	
BCG	Date	Skin test? Visible Scar? Y N
Diphtheria	Date	
Poliomyelitis	Date	
Tetanus	Date	
Varicella	Date	
MMR (Measles, Mumps, Rubella)	Date	
HIV	Date	
Tetanus	Date	

I hereby declare that the answers I have given to the above questions are true to the best of my knowledge and beliefs. I understand that any intentionally false statement may cause my service with my employer to be terminated.

Signed: _____ Date: _____

MEDICAL HEALTHCARE PROFESSIONALS

PAYMENT AND FINANCIAL DETAILS FORM

PERSONAL DETAILS

TITLE: Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

SURNAME	
FORENAMES	
DATE OF BIRTH	(mm/dd/yy)
ADDRESS	
POSTCODE	

BANK DETAILS

BANK / BUILDING SOCIETY NAME	
BANK ADDRESS	
ACCOUNT HOLDER'S NAME	
ACCOUNT NUMBER	
SORT CODE	

LIMITED / UMBRELLA COMPANIES

COMPANY NAME	
COMPANY ADDRESS	
BANK / BUILDING SOCIETY NAME	
BANK ADDRESS	
SORT CODE	
ACCOUNT NUMBER	

I confirm that the above information is correct.

_____ NAME AND SIGNATURE

_____ DATE