



Countrywide Medical Selection Limited

<b>Personal Details</b>	
Surname	
First Name	
Title (e.g. Mr/ Mrs/ Miss/ Ms)	
Date of Birth	
National Insurance Number	
<b>If you have been known by another name (e.g. maiden name/ deed poll change) please provide to us in the space below all previous names and dates they were changed.</b>	
Present UK address	
Post Code	
Country	
Home Tel	
Work Tel	
Mob Tel	
Email Address	
HPC Registration Number	
Registration Number Expiry Date:	

<b>In Case Of Emergency – (Next of Kin Details)</b>	
Title (e.g. Mr/ Mrs/ Miss/ Ms)	
First Name	
Surname	
Home Tel	
Work Tel	
Mob Tel	
Email Address	
Postal address	



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Passport Details	
Nationality	
Country of Origin	
Do you hold a UK/ EU Passport? Please Specify	
If No, Please State Issuing Country	
What type of Visa do you hold for UK entry?	
Expiry Date of Visa	

Education/ Professional Qualifications			
Please supply a copy of all your Professional Certificates or Documents. (Where possible please provide the names of your training body so that we can verify your qualifications)			
University/ College	Qualification	Commencement DD/MM/YYYY	Qualified Date DD/MM/YYYY

Training			
Please specify the dates of the following Mandatory Training Courses attended and supply copies of certificates.			
Course Title	Yes (Please Tick)	No (Please Tick)	Expiration Date;
Manual Handling			
Basic Life Support (CPR)			
Paediatric Basic Life Support (CPR)			
Online 1-9 (9 modules)			
POCA			
POVA			

Work Requirements	
Current Job Title	
Current Band	
Available From (DD/MM/YYYY):	Available To (DD/MM/YYYY):
In which geographical areas would you like to work?	
In which grade & specialty are you looking to work?	
Do you hold a current full driving licence?	
If yes, in what country?	
Do you have your own vehicle?.	



Languages spoken (Please indicate fluency):	
Would you require hospital accommodation?	

<b>Clinical Preferences</b>			
Please tick from the list below which Clinical Areas you would like to work in based on your current experience.			
Acute Mental Health	Medical/ Surgical	Social Services	Paediatrics
Adult Mental Health	Orthopaedics	Intermediate Care	
Older Peoples Mental Health	Care of the Elderly	Community Rehab	
CAMHS (Children & Adolescent Mental Health Service)	Neurology including Stroke	Respiratory	
Forensic Mental Health	A&E	MSK	
Community Mental Health	Hand Injuries		
Learning Disabilities	Oncology/Palliative Care	Women's Health	
Other (Please Specify) :			

<b>Employment History</b>				
YOU MUST COVER AT LEAST THE LAST 5 YEARS, starting with your most recent Employer. All gaps in work history must be accounted for. Please use additional information page if necessary.				
Employer/ Organisation	From (DD/MM/YYYY):	To (DD/MM/YYYY):	Job Title/ Band	Duties
Employer/ Organisation	From (DD/MM/YYYY):	To (DD/MM/YYYY):	Job Title/ Band	Duties
Employer/ Organisation	From (DD/MM/YYYY):	To (DD/MM/YYYY):	Job Title/ Band	Duties
Employer/ Organisation	From (DD/MM/YYYY):	To (DD/MM/YYYY):	Job Title/ Band	Duties



### Professional References

Please provide contact details of PROFESSIONAL referees from your last 5 years of employment, ensuring to include you two most recent employers (Clinical Supervisors or equivalent) Professional addresses only.

Hospital/ Organisation		Hospital/ Organisation	
Contact Name		Contact Name	
Position		Position	
Address		Address	
Tel Number		Tel Number	
Mob Number		Mob Number	
Fax Number		Fax Number	
Email Address		Email Address	

Hospital/ Organisation		Hospital/ Organisation	
Contact Name		Contact Name	
Position		Position	
Address		Address	
Tel Number		Tel Number	
Mob Number		Mob Number	
Fax Number		Fax Number	
Email Address		Email Address	

Hospital/ Organisation		Hospital/ Organisation	
Contact Name		Contact Name	
Position		Position	
Address		Address	
Tel Number		Tel Number	
Mob Number		Mob Number	
Fax Number		Fax Number	
Email Address		Email Address	



**How Did You Hear Of Us?**

**Which agencies are you registered with in addition to CMS?**

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**Rehabilitation of Offenders Act 1974 (Exceptions 1975)**

Due to the type of 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 Rehabilitation of Offenders Act 1974 (amendment order 1986). Applicants are therefore required to give information about convictions which for other purposes are then “spent” under the provision of the Act. Any such information provided will be totally confidential and will be considered only in relation to an application for the positions to which the Order applies.

Please sign if you have no such declarations

*Please supply details of any convictions on a separate sheet*

**Criminal Records Bureau / Overseas Police Certificates**

If you are an overseas applicant who is due to or has entered the UK in the last six months we require an original police check from your country of origin dated no more than 3 months prior to your departure and enclose it with this form.

If you hold a UK Enhanced Disclosure which was issued within the last 12 months, please forward us a copy

If you have not done so already, please complete and return the CRB Questionnaire which is contained within the Registration Email.

**Perm Candidates ONLY:**

Countrywide Medical Selection are to provide you permanent recruitment services that is to say we will act as an agency as defined under the Employment Agencies Act 1973.

You authorise Countrywide Medical Selection to seek work on your behalf within the field of Nursing.



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### **Applicant Declaration**

I confirm that the details contained within this Registration form are correct and give my consent for Countrywide Medical Selection to retain this information in line with the Data Protection Act (1998).

I understand that any registration is subject to the receipt of satisfactory references and a satisfactory Enhanced level CRB check. I understand that my personal data and CV may be passed to Countrywide Medical Selection clients prior to my placement in any assignment, but this will simply be to ascertain my suitability for roles that Countrywide Medical Selection considers me appropriate for. I consent to references being sent to third parties.

I understand that Countrywide Medical Selection are not obliged to offer me assignments and I in turn am not obliged to accept assignments offered.

Printed Name: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_



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## NEW EMPLOYEE MEDICAL QUESTIONNAIRE

### CONFIDENTIAL

The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake the duties of the post you have been offered or place you at any risk in the workplace. We may recommend adjustments or assistance as a result of this assessment to enable you to do the job. Our aim is to promote and maintain the health of all people at work. Before health clearance is given for employment you may be contacted by the Healthier Business UK Ltd and may need to be seen by an occupational health advisor or physician.

Personal Information			
Title	Surname	First names	DOB
Home Tel:	Work Tel:	Mobile:	
Home Address:		GP Address:	

Medical History		
<u>All staff groups complete this section</u>	Yes	No
Do you have any illness/impairment/disability (physical or psychological) which may affect your work?	<input type="checkbox"/>	<input type="checkbox"/>



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Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having, or waiting for treatment (including medication) or investigations at present? If your answer is yes, please provide further details of the condition, treatment and dates	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you may need any adjustments or assistance to help you to do the job?	<input type="checkbox"/>	<input type="checkbox"/>

**Additional Information**

**(If you have answered yes to any questions above please provide additional information below)**

**Tuberculosis**

Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006)	Yes	No
Have you lived continuously in the UK for the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
If you answered no above, please list all of the countries that you have lived in over the last 5 years		



Have you had a BCG vaccination in relation to Tuberculosis?		<input type="checkbox"/>	<input type="checkbox"/>
If you answered yes please state when	Date		
<b>Tuberculosis Continued</b>			
Do you have any of the following	Yes	No	
A cough which has lasted for more than 3 weeks	<input type="checkbox"/>	<input type="checkbox"/>	
Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>	
Unexplained fever	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had tuberculosis (TB) or been in recent contact with open TB	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Additional Information</b>
(If you have answered yes to any questions above please provide additional information below)

<b>Chicken Pox or Shingles</b>		
Have you ever had chicken pox or shingles		
<b>Yes</b>	<b>No</b>	<b>Date</b>

<b>Immunisation History</b>			
Have you have any of the following immunisations	<b>Yes</b>	<b>No</b>	<b>Date</b>
Triple vaccination as a child (Diphtheria / Tetanus / Whooping cough)			



Polio								
Tetanus								
Hepatitis B (If Yes is ticked please give dates below)								
Course:	1		2		3			
Boosters:	1		2		3			

Proof of Immunity (Please send the following)	
<b>Varicella</b>	You must provide a written statement to confirm that you have had chicken pox or shingles however we <b><u>strongly advise</u></b> that you provide serology test result showing varicella immunity
<b>Tuberculosis</b>	We require an occupational health/GP certificate of a positive scar or a record of a positive skin test result <b><u>(Do not Self Declare)</u></b>
<b>Rubella, Measles &amp; Mumps</b>	Certificate of <b><u>"two"</u></b> MMR vaccinations or proof of a positive antibody for Rubella Measles & Mumps
<b>Hepatitis B</b>	You must provide a copy of the most recent pathology report showing titre levels of 100lu/l or above
Proof of Immunity (Please send the following) EPP Candidates Only	
<b>Hepatitis B Surface Antigen</b>	Evidence of a negative Surface Antigen Test Report must be an identified validated sample. (IVS)
<b>Hepatitis C</b>	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)
<b>HIV</b>	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)

**Exposure Prone Procedures**



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Will your role involve Exposure Prone Procedures	Yes	No
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Declaration		
I declare that the answers to the above questions are true and complete to the best of my knowledge and belief. I also give consent for the Healthier Business UK Ltd to make recommendations to my employer.		
Name	Signature	Date



Refusal of HIV Screening Form (For Non Exposure Prone Procedure Workers NEW To NHS)

\*Please note: Compulsory to complete if screening is refused or proof not available

Forename	Surname
Address	Postcode:
Date of Birth	

I hereby confirm that I refuse to undergo a HIV Screening

Signature.....Date.....

I also accept that my agency "Countrywide Medical Selection" have informed me of the risk of working without undergoing HIV Screening.

Signature.....Date.....

Risk of contracting HIV:

Listed below are ways that you might have been exposed to HIV in the past or in the future:

- If they are male, engaging in unprotected sexual intercourse with another man;
- having unprotected intercourse in, or with a person who had been exposed in a country where transmission of HIV through sexual intercourse between men and women is common;
- sharing injecting equipment while misusing drugs;
- having a significant occupational exposure to HIV-infected material in any circumstances;
- engaging in invasive medical, surgical, dental or midwifery procedures, either as a practitioner or patient, in parts of the world where infection-control precautions may have been inadequate, or with populations with a high prevalence of HIV infection;
- engaging in unprotected sexual intercourse with someone in any of the above categories.



Refusal of Hep C Screening Form (For Non Exposure Prone Procedure Workers:

\*Please note: Compulsory to complete if screening is refused or proof not available

Forename	Surname
Address:	Postcode:
Date of Birth	

I hereby confirm that I refuse to undergo a Hep C Screening

Signature.....Date.....

I also accept that my agency "Countrywide Medical Selection" have informed me of the risk of working undergoing Hep C Screening.

Signature.....Date.....

Risk of contracting Hep C:

Listed below are ways that you might have been exposed to hepatitis C:

- receipt of unscreened blood or untreated plasma products (in the UK before September 1991 and 1986 respectively);
- sharing of injecting equipment while using drugs;
- having been occupationally exposed to the blood of patients known to be infected with Hep C, or deemed to be at high risk of infection, by sharps or other injuries (and not subsequently screened and shown to be non-infectious);
- receiving medical or dental treatment in countries where hepatitis C is common and infection-control precautions may be inadequate.

**BCG Scar Declaration Form**

Section to be completed by candidate

Personal Information			
Title: Mr, Mrs, Ms, Miss, Dr	Surname	First names	DOB
Home Tel:	Work Tel:	Mobile:	
Home Address:		GP Address:	

**Section to be completed by Health Care Professional (BCG Scar cannot be self declared)**

Personal Information			
Title: Mr, Mrs, Ms, Miss, Dr	Surname	First names	GMC OR NMC PIN Number
Address	Post code	Telephone	Fax

Screening Results BCG Scar		
Location of scar	Size of scar	Date that scar was sighted

Screening Results Mantoux – Heaf if no scar present	
Mantoux- The above named patient had a induration 6mm or greater, but less than 15mm so therefore is considered immune/protected against Tuberculosis	<input type="checkbox"/>
Heaf Test- The above named patient has a Grade 2 (II) result so therefore is considered immune/protected against Tuberculosis	<input type="checkbox"/>

Declaration



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I hereby certify that I'm competent and have received appropriate training in the administration and reading of mantoux skin testing and BCG Vaccination Scars.

Name	Date	Signature
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**Proof of Hepatitis B course + boosters**

<b>Patient/candidates name</b>	
<b>Date of birth</b>	
<b>Address</b>	
<b>Hepatitis B history</b> <b>(To be completed by your GP or Occupational Health department)</b>	
Date of Innoculation	Administer by (if known)
<b>Boosters required /due</b> <b>(To be completed by your GP or Occupational Health department)</b>	
Date booster is due	

Please note we still require serological (pathology report) evidence of immunity to Hepatitis B

<b>Declaration</b>
I herby confirm that the information detailed with this form is present and correct  (To be completed by your GP or Occupational Health department)



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Name		Position	
Signature		Date	
GMC/NMC no			

**In order to help with our verification process please ensure that this document is stamped.**

**CONSENT FOR RELEASE OF MEDICAL RECORDS FOR AUDIT PURPOSES**

**YOUR DETAILS:**

FULL NAME: .....

ADDRESS:

POSTCODE:

DAYTIME TELEPHONE NUMBER: .....

DATE OF BIRTH: .....

**ACCESS TO MEDICAL REPORTS ACT 1988 AND THE DATA PROTECTION ACT 1998**

I hereby consent to a medical report or full medical records being supplied in confidence by Healthier Business Ltd to Buying Solutions (formerly know as NHS PASA), for audit purposes.

I have been informed of my statutory rights under the Access to Medical Reports Act 1988 and the Data Protection Act 1998 having read the summary of my principal rights under the Acts as set out overleaf.

**I do require to see any medical reports before they are forwarded to Buying Solutions.**

**I do not require to see any medical reports before they are forwarded to Buying Solutions.**

\* (Please delete as appropriate)

Tel:.....

**Signature : ..**

**Date: ..**

**CONSENT TO MEDICAL CONSULTATION / EXAMINATION AND/OR REPORT**

I hereby agree to a report being provided to Buying Solutions on the basis of the medical information received by Healthier Business Ltd.

If a medical consultation is being requested I understand that this consultation might incorporate a physical examination and such additional tests as the examining doctor might feel necessary, the nature of which will be explained to me.

I consent to a report being sent in confidence to my employer and buying Solutions. I understand that the report will include appropriate information and recommendations about my medical conditions in relation to my current and potential future fitness for work.

**Signature : .. X.. .....**

**Date: ... X.....**



**The attached form has two sections. The first– The Access to Medical Reports Act 1988 Consent form - allows Healthier Business Ltd to release medical records to Buying Solutions for audit purposes.**

**The second section requests your consent to a Medical Examination/Consultation with a Occupational Physician, in case such a consultation is needed, and for the provision of a report, respecting your confidentiality, to your employer.**

YOUR CONSENT IS REQUESTED FOR BOTH SECTIONS (EVEN IF YOU ARE NOT REQUIRED TO HAVE A  
MEDICAL AT THIS POINT)  
ACCESS TO MEDICAL REPORTS ACT 1988  
Summary of your rights under the Act

- 1 You can withhold your consent to the report/records being provided.
- 2 You have 21 days in which to ask Healthier Business Ltd to show you the report/records before we send it to Buying Solutions for audit purposes.
- 3 You can ask Healthier Business Ltd either to amend any part of the report/records which you consider to be misleading or, if the we do not agree to change it, you may add your own comment to the report/records. You may also withdraw your consent at that time.
- 4 There are certain circumstances under which Healthier Business Ltd may withhold the report/records or part of the report/records from you if such action is felt to be in your best interests. Healthier Business Ltd will inform you in writing that access is being denied but that access may still be allowed to any part of the report not covered by the exemptions
- 5 If you decide at the moment not to see the report/records you will still have six months in which to change your mind and to contact Healthier Business Ltd for a copy of the report/records. If you indicate on the Consent Form below that you do not wish to see the report then Healthier Business Ltd can send it to Buying Solutions immediately.



DATA PROTECTION ACT 1998

1. General information that identifies an individual is known as personal data.
2. Information regarding health, medical history and any treatment you have received is known as sensitive data.
3. Your explicit written consent is required to obtain and process any sensitive data about you.
4. You have the right of access to information we hold about you. This information is subject to medical confidentiality guidance which aims to protect you from physical or mental harm when reading about your state of health and means the doctor acting for your company will review the information before it is sent to you.
5. If you believe the information is inaccurate or misleading you can request an amendment is attached to the information.
6. If you want to have access to any information we hold about you, your request must be made in writing to us. A check will be made to verify you are the person seeking the information. In certain circumstances a charge may be made for the release of information. You will be informed of any charge in writing.
7. If a report reveals information about a person other than yourself, that part of the report must be kept from you.
8. All enquiries should be made (in writing) to your agency or Healthier Business Ltd.



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## Countrywide Medical Selection CRB Questionnaire Form

The information Entered into the following Form will be used to Apply for your UK Enhanced CRB Disclosure.

Title (Mr, Mrs, Miss, Ms, Other)	
Surname	
Forename(s)	
Current Address	
Post Code	
At Current Address Since	
Date Of Birth (DD/MM/YYYY)	
Gender	
Position Applied for	
Surname(s) At Birth (if different)	
Used From (YYYY) and Used until (YYYY)	
Town/City of Birth	
County/District of Birth	
Born In The UK (Yes or No)	
Nationality	
Contact Telephone Number	
Passport Number & Issuing Country (i.e. British, South African)	
Issue Date	
If you do not have a valid passport please complete below:	
Driving Licence Number (only UK issued photo card) (18 digits long)	
Valid From	

We need 5 years continuous address history (UK or Overseas) with all gaps accounted for. If you have not lived at your current address for 5 years, please complete on the page supplied. Thank you.



### Countrywide Medical Selection CRB Questionnaire Form- Continued

Address: \_\_\_\_\_  
\_\_\_\_\_

Postcode: \_\_\_\_\_

From: (MMYYYY) \_\_\_\_\_ Until: (MMYYYY) \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Postcode: \_\_\_\_\_

From: (MMYYYY) \_\_\_\_\_ Until: (MMYYYY) \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Postcode: \_\_\_\_\_

From: (MMYYYY) \_\_\_\_\_ Until: (MMYYYY) \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Postcode: \_\_\_\_\_

From: (MMYYYY) \_\_\_\_\_ Until: (MMYYYY) \_\_\_\_\_