

Address: 33A Ashtree Road, Norwich, NR5 0LR  
Tel: 01603 339007  
Email: [recruitment@msmhealthcare.co.uk](mailto:recruitment@msmhealthcare.co.uk)  
Website: [www.msmhealthcare.co.uk](http://www.msmhealthcare.co.uk)

## Job Application Form

**Vacancy Title:**

**Please tell us how you heard about this vacancy:**

### 1. Personal details

**Last Name:**

**First Name:**

**Address:**

**Postcode:**

**Home Telephone No.**

**Daytime Contact No.**

**E-mail address:**

**National Insurance No.**

**Date of Birth:**

Do you hold a full driving licence valid in the UK?

Yes  No

### 2. Preferred hours

**We like our workers to be willing to work flexibly across the week and need to know when other commitments mean you could not be available to work:**

Please tick which days you prefer to work:

	Mon	Tues	Weds	Thurs	Fri	Sat	Sun
Days							
Nights							

### 3. Education/Qualifications

High School	Study Dates	Qualification and Grade	Date Obtained
College/University	Study Dates	Qualification and Grade	Date Obtained
Ongoing Professional Development	Study Dates	Qualification and Grade	Date Obtained

### Training and Development

Please use the space below to give details of any training or non-qualification based development which is relevant to the post and supports your application.

Training Course	Course Details (including length of course/nature of training)

### Current Membership of any Professional Body/Organisation

Please give details:

## 4. Employment History

**Previous Employment:** Please include any previous experience (paid or unpaid), starting with the most recent first.

**Current or most recent employer**

**Name of Employer:**

**Address:**

**Postcode:**

**Position Held:**

**Date Started:**

**Leaving Date:**

**Reason for Leaving:**

**Contact Name of Line Manager for reference:**

**Brief description of duties:**

**Previous employer**

**Name of Employer:**

**Address:**

**Postcode:**

**Position Held:**

**Date Started:**

**Leaving Date:**

**Reason for leaving:**

**Contact Name of Line Manager for reference:**

**Brief description of duties:**



# Application Form

Previous Employment: (Continued)

**Current or most recent employer**

Name of Employer:

Address:

Postcode:

Position Held:

Date Started:

Leaving Date:

Reason for Leaving:

Contact Name of Line Manager for reference:

Brief description of duties:

**Previous employer**

Name of Employer:

Address:

Postcode:

Position Held:

Date Started:

Leaving Date:

Reason for leaving:

Contact Name of Line Manager for reference:

Brief description of duties:

## 5. Convictions/ Disqualifications

To ensure the safety of our clients an Enhanced DBS (formerly CRB) check must be completed for all positions. A criminal record will not necessarily be a bar to obtaining a position with MSM Healthcare. If a check is returned and reveals any information, this will be discussed with the applicant. The Director(s) will make a decision as to whether the offer of employment should be withdrawn.

### **Rehabilitation of Offenders Act 1974 (Exceptions)(Amendment) Order 1986**

**We would draw your attention to the following statement:-**

“Because of the nature of the work for which you are applying, this post is exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act, 1974, by virtue of the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 and the Rehabilitation of Offenders Act 1974 (Exceptions) (Amendment) Order 1986.

Applicants are, therefore, obliged to disclose information about any convictions which for other purposes would be regarded as ‘spent’ under the provisions of the Act”. Failure to disclose such convictions could result in dismissal or disciplinary action by the employing organisation. Any information given will be confidential and will be considered only in relation to any post to which the conviction applies.

**Have you at any time received or had pending, a court conviction in the UK or overseas? If yes please give details.**

**Yes** **No**

**Are you aware of any Police enquiries undertaken following allegations made against you, in the UK or Overseas? If yes please give details.**

**Yes** **No**

**Are you subject to any fitness to practice conditions or have you been suspended or dismissed from any job?**

**YES** **No**

If "yes" please give details in the space below?

**If appointed when could you start? Give period of notice if applicable**

## 6. References

Please give the detail of **two** references. We will take up professional references once you have been interviewed and **provisionally** offered a post. Please make sure that you have given the full contact details of your referees so that this does not delay processing reference requests.

If you have no employer references, we will take up references with named individuals at colleges where you have studied, or people who know you in a professional capacity. Please do not put down family members or people you live with as referees.

**Name of Referee  
and relationship  
to you:**

**Address:**

**Email:**

**Postcode:**

**Tel:**

**Name of Referee  
and relationship  
to you:**

**Address:**

**Email:**

**Postcode:**

**Tel:**

## 7. Bank Details

Will you be working as 'Pay As You Earn' (PAYE), or paid through a Limited or Umbrella Company?  
Please give the details of your Ltd or Umbrella Company provider (if applicable). Ltd Company workers will need to provide copies of certificate of incorporation and VAT registration certificate.

PAYE

Ltd Company

Umbrella Company

Name of Bank: \_\_\_\_\_

Name of Account Holder: \_\_\_\_\_

Address of Bank: \_\_\_\_\_

Account Number: \_\_\_\_\_

\_\_\_\_\_

Sort Code: \_\_\_\_\_

Post Code: \_\_\_\_\_

P45 enclosed?      Yes       No

P46 requested?      Yes       No

## 8. Working Time Regulations

The Working Time Regulations 1998 state that you are unable to work in excess of an average of 48 hours per week (calculated over a 17 week period) unless agreed with the MSM Healthcare Personnel that this limit should not apply.

MSM Healthcare wishes to have an agreement with you, which will apply until terminated by notice:

- I. The average 48 hour work limit will not apply to you.
- II. This agreement may be terminated by yourself by giving MSM Healthcare 4 weeks written notice.

If you accept this proposal please sign below. This section of the application form will then be a record of this agreement between you and MSM Healthcare.

**Signed:**

**Date:**

## 9. Declaration

### Statement to be Signed by the Applicant

Please complete the following declaration and sign it in the appropriate place below. If this declaration is not completed and signed, your application will not be considered.

**I agree that MSM Healthcare can create and maintain computer and paper records of my personal data and that this will be processed and stored in accordance with the Data Protection Act 1998.**

**I confirm that all the information given by me on this form is correct and accurate and I understand that if any of the information I have provided is later found to be false or misleading, any offer of employment may be withdrawn or employment terminated.**

**Signed:**

**Date:**

**Print Name:**



# Application Form

## Equal Employment Opportunities Monitoring Questionnaire

### Confidential

MSM Healthcare is an equal opportunities employer and will ensure that no job applicant or employee receives less favourable treatment particularly on the grounds of sex, race, colour, nationality, ethnic origin, marital status, disability, sexuality, age, religious belief, political belief, trade union activity, responsibility for dependants, employment status or HIV status.

Please complete this form and return it with the main Application Form to assist MSM Healthcare in monitoring its Recruitment and Selection process. In addition, the information will form part of the employment record for the successful applicant and will be used by MSM Healthcare for later equal opportunities monitoring purposes throughout the period of employment.

**This form is not made available to those conducting the recruitment interview.**

PLEASE COMPLETE IN BLACK INK OR TYPE SCRIPT

- 1. Sex**                      Male                      Female
- 2. Date of birth**                      \_\_\_\_\_
- 3. Marital status**                      Married                      Unmarried                      Other\* (please specify)
- \_\_\_\_\_

\* E.g. Individuals who are widowed but have not remarried, individuals who are separated, individuals who are living with a partner etc

- 4. Disability**                      It is recognised that disabled people are not only those whose disability is immediately apparent (eg blind people or those in wheelchairs) but also those whose disability is not immediately obvious (eg heart trouble, mental illness or diabetes)

Do you consider yourself as having a disability?    Yes                      No

- 5. Ethnic origin**                      Individuals should identify with which one of the undernoted categories they most closely associate themselves, having regard to their ethnic or cultural background.

- White: Scottish                      White: British                      White: Irish
- White: Other (please specify)
- Black: Caribbean                      Black: African
- Black: Other (please specify)
- Indian                      Pakistani                      Bangladeshi                      Chinese
- Asian: Other (please specify)
- Any Other Ethnic Group (please specify)

### 8. Post applied for

**Print Name:**

**Signed:**

**Job Reference:**

**Date:**



## HEALTH SELF DECLARATION FORM

**PLEASE NOTE:** If you falsify any information on this form, or fail to mention anything relating to your health which may later come to light, you may be liable for disciplinary action including immediate suspension.

**You are required to complete the Health Self Declaration Assessment below which must be signed and returned to MSM Healthcare Agency prior to the start date.**

1. Do you have any illness/impairment/disability (physical or psychological) which may affect your work, your own health, safety and welfare, or that of others?    Yes                      No    If **yes**, please give details below:

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2. Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?    Yes                                      No                                      If **yes**, please give details below:

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3. Are you having, or waiting for treatment (including medication) or medical investigation at present?    Yes                      No                      If your answer is **yes**, please provide further details of the condition, treatment and dates below.

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4. Do you think you may need any adjustments or assistance to help you to do the job?    Yes                                      No                                      If **yes**, please give details below:

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5. Do you have any of the following?	Yes	No
(a) A cough which has lasted for more than 3 weeks?	Yes	No
(b) Unexplained weight loss?	Yes	No
(c) Unexplained fever?	Yes	No
(d) Have you had tuberculosis (TB) or been in recent contact with open TB?	Yes	No

If **yes** to any of the above, please give details below:

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**As a health care worker, you are under ethical and legal duties to protect the health and safety of the individuals in your care. All information disclosed will be processed in accordance with the requirements of the Data Protection Act**

### Nursing and Allied Professionals Only:

6. Have you ever had chickenpox/varicella?                      Yes                       No

7. Can you provide documented evidence of immunity to measles, mumps and rubella?    Yes                      No

8. Have you had a BCG vaccination in relation to Tuberculosis?    Yes                       No

9. Have you ever had a Hepatitis B test in the last 5 years?    Yes                       No

If **yes** to any of the above, please give details below:

Please provide the following details of your immunisation record:

	Yes	No	Dates
Tetanus			
Diphtheria			
Poliomyelitis			
Hepatitis A			
Hepatitis B (showing titre levels > 100miu/ml)			
Rubella (German Measles)			
Varicella			
BCG (Tuberculosis vaccination)			

I declare that all of the information provided regarding my declaration of health and immunisation record is true to the best of my knowledge and I will endeavour to inform MSM Healthcare of any changes in my health circumstances that may affect my ability to work.

Signed:

Date:

Print Name:

Please return this form with your application

Thank you

## APPLICATION CHECKLIST

In order to ensure that we can register and clear you as quick as possible please use the following checklist to ensure that you have all the documents required:

1. Completed DBS application form for England or Scotland
2. The necessary documents to confirm your identity <https://www.gov.uk/disclosure-barring-service-check/documents-the-applicant-must-provide->
3. MSM Healthcare application form fully completed
4. Details of 2 referees – current and last employers including e-mail addresses
5. Evidence of the right to work in the UK
6. Original/Certified Registration certificates, professional qualifications, memberships of prof bodies
7. NMC Original Statement of Entry or HPC Equivalent
8. NMC Annual Statement of Entry or HPC Equivalent
9. Latest CV
10. Occupational Health questionnaire
11. Proof of professional indemnity cover (Qualified Staff)
12. Agency worker handbook declaration
13. Police check from country of origin – if you have been in the UK less than 6 moths.
14. Original IELTS Certificate - if applicable to you

### **Annual Training Certificates:**

1. Basic Life Support
2. Manual Handling

The following courses are available as On-Line courses at this link:

[www.osmosistraining.co.uk](http://www.osmosistraining.co.uk)

3. Fire Safety
4. Lone worker Training
5. Handling of Violence & Aggression
6. The Caldicott Protocols
7. Health & Safety: COSHH & RIDDOR
8. Infection prevention & control, including MRSA & Clostridium Difficile
9. Complaints Handling
10. Child Protection
11. Epilepsy
12. Protection of Vulnerable Adults (POVA)
13. Food Safety

### **Original Documents:**

We are required to verify all original documents. We will scan any original documents that you bring. If you bring copies we require a copy of each and every page, i.e. for passports and travel documents, a copy should be taken of the document's front cover and any page containing the holder's personal details. In particular, you should copy any page that provides details of nationality, your photograph, date of birth, signature, date of expiry or biometric details.

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