Candidate Application Form

ACCESS HEALTHCARE

Personal Details

Surname:

Forenames:

Title: *(Please Tick)* Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Address: Eircode:

PPS Number: Social Care Worker ☐ Midwife ☐ Occupation Nurse ☐ Healthcare Assistant ☐

Email address:

Tel Mobile: Home:

Date of Birth: Sex: Male ☐ Female ☐

Bank Details

IBAN: BIC:

Emergency Contact

Name: Relationship:

Tel Number:

Eligibility Of Employment

EU Passport or GNIB Card: ☐ Nationality (as per passport):

Please send a scanned copy of passport and visa where applicable with this application form and bring originals to your interview.

Source

Where did you hear about us? *(Please Tick)*

Referral: ☐ (Please Specify Name):

Professional Healthcare References

At least two references are required.

Organisation:	Department:
Name:	Title:
Address:	
Contact Tel:	Email:
Period of employment:	
Start date:	End date:

Organisation:	Department:
Name:	Title:
Address:	
Contact Tel:	Email:
Period of employment:	
Start date:	End date:

Organisation:	Department:
Name:	Title:
Address:	
Contact Tel:	Email:
Period of employment:	
Start date:	End date:

Mandatory Safety Checklist

Please state whether you have up to date certification of the following: (Please Tick)

CPR/Basic Life Support	Yes: ☐	No: ☐
Patient Moving & Handling	Yes: ☐	No: ☐
Infection Prevention & Control	Yes: ☐	No: ☐
Elder Abuse Training	Yes: ☐	No: ☐
Personal Protective Equipment	Yes: ☐	No: ☐
Hand Hygiene	Yes: ☐	No: ☐
Fire & Safety	Yes: ☐	No: ☐
Safeguarding Vulnerable Adults	Yes: ☐	No: ☐
Children First Training	Yes: ☐	No: ☐
Fundamentals of GDPR	Yes: ☐	No: ☐
Management of Violence & Aggression TCI/PMVA	Yes: ☐	No: ☐
Mental Health Act 2001	Yes: ☐	No: ☐

Professional Qualification *(Please Tick)*

NMBI Retention Certificate *(Nurses only)*	Yes: ☐	No: ☐
Fetac Level 5 or Equivalent *(HCA only)*	Yes: ☐	No: ☐
Student Nurse ID	Yes: ☐	No: ☐
Social Care Degree/Certification	Yes: ☐	No: ☐

Proof of Occupational Health *(Please Tick)*

Immunity to MMR	Yes: ☐	No: ☐
Immunity to Varicell	Yes: ☐	No: ☐
HEP B	Yes: ☐	No: ☐

Record Of Experience

(For Nurses Only)

	Course (Please Tick)	Experience (Number of Years)	Duration/Comments (Months/Years /Additional Information)
1. A & E	☐		
2. Burns / Plastic	☐		
3. Cardio Thoracic	☐		
4. CCI	☐		
5. ENT	☐		
6. Geriatrics	☐		
7. ICU (Adults)	☐		
8. ICU (Paeds)	☐		
9. IVC Policy	☐		
10. Medical	☐		
11. Midwifery	☐		
12. Neonates	☐		
13. Nephrology	☐		
14. Neurosurgery	☐		
15. Obstetrics / Gynae	☐		
16. Occ Health	☐		
17. Oncology	☐		
18. Orthopaedics	☐		
19. Paediatrics	☐		
20. Phlebotomy	☐		
21. Psychiatry	☐		
22. Renal	☐		
23. Special Care (Babies)	☐		
24. Surgical	☐		
25. Theatre / OR	☐		
26. Non-violent Crisis Intervention (Psychiatric Nurses only)	☐		
27. OTHER	☐		

Additional Comments:

Medical History

Confidential

This section of our application form seeks to establish whether you have any health issues that could affect your ability to perform your duties at work or that would result in risk to you at work. On completing our assessment of your responses we may recommend a course of action to enable you to work safely.
You may be contacted in this regard and we may recommend that you see an occupational health advisor or medical practitioner prior to providing any engagements to you. These records will be held on file as part of our application form.

Medical History *(Please Tick)*

Do you have any illness/impairment/disability which may affect your employment?	Yes: ☐	No: ☐
Have you ever had any illness/impairment/disability which may have been caused or made worse by your employment?	Yes: ☐	No: ☐
Do you think you may need any adjustments or assistance to help you to carry out your work?	Yes: ☐	No: ☐
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.	Yes: ☐	No: ☐

If you have answered 'yes' to any of the above questions please provide further details.We cannot proceed with your application without this detail.

Tuberculosis (TB) *(Please Tick)*

Have you had a BCG vaccination in relation to Tuberculosis?	Yes: ☐	No: ☐
If yes, please provide date:		
Have you ever had TB or any symptoms of TB i.e. unexplained weight loss,unexplained fever, a cough which has lasted for more than 3 weeks?	Yes: ☐	No: ☐

If you have answered yes to any questions above, please provide additional information below:

The information above is true and I agree to inform Access Healthcare and any employer at which I am placed of any health problems so that my health and safety and that of my patients can be protected whilst at work.

Signed:	
Print name:	Date:

Declarations and Authorisations

Please Read Each Point Below Carefully:

I, Name:	Date of Birth:
Address:	

HEREBY DECLARE that:

1. I have never been arrested for, or convicted of, any offence or crime (other than an offence under road traffic legislation), either in Ireland or in any other state;
2. I understand that if I am at any stage charged or cautioned after signing this declaration, I must inform Access Healthcare.
3. I have never been the subject of a pardon or amnesty or other similar legal action in respect of any offence or crime (other than an offence under road traffic legislation for which a penalty of imprisonment is not enforceable);
4. I have never unlawfully distributed or sold a controlled substance (drug);
5. I am not currently nor have I ever been to my knowledge under investigation by the Garda Siochana/Police force of any state in relation to the commiting of a crime (other than an offence under road traffic legislation for which a penalty of imprisonment is not enforceable);
6. I confirm that I am not currently under investigation, or currently suspended, by my professional regulatory body or being investigated by my current or previous employer. I will inform Access Healthcare if I am under investigation or suspended by my professional regulatory body or employer at any point while working for Access Healthcare.
7. I acknowledge that my personal details will be stored and handled correctly by Access Healthcare in accordance with the General Data Protection Regulation, however, I agree that they may be made available for audit/review by relevant third parties. (This is relevant for all information including all documents – Garda Vetting, Occupational Health, References).
8. I give permission to Access Healthcare to confirm reference letters with the referees and to validate passport and GNIB Cards with the passport office and immigration.
9. I agree that Access Healthcare can send me texts and emails regarding jobs and relevant information.
10. I give permission to Access Healthcare to give copies of relevant documents to the relevant appraisal bodies including the HSE for Auditing purposes.
11. I give permission to Access Healthcare to give my timesheets to Clients for auditing purposes and for the purpose of verification of signatures and to authorize payment.
12. I give Access Healthcare permission to use my date of birth when verifying my registration by email with the Nursing and Midwifery Board of Ireland (NMBI).
13. I acknowledge that I have been given a copy of the terms and conditions of service issued by Access Healthcare which is mine to keep, and furthermore that I have read those terms and conditions and agree to abide by them.
14. I am not aware of any condition, medical or otherwise, which would affect or limit my employment or performance, other than those declared in my occupational Medical History on this form.
15. I acknowledge and confirm that Access Healthcare is authorised to apply for and obtain a Garda Vetting check and references from any previous employers and educational establishments.
16. I agree that the maximum weekly working time specified in Regulation 4(1) of the Organisation of Working Time Act 1997 shall not apply to working with Access Healthcare.
17. I understand that if I am on a student visa I can only work 20 hours per week during term time. I understand that I have a responsibility to monitor this, in addition, if my position as a student changes, I must inform Access Healthcare.
18. I acknowledge that if any of my details stated on this Application Form change, or my circumstances change, which may affect my ability to work for Access Healthcare, I must inform Access Healthcare.
19. I confirm that when asked about my working history (primarily, but not exclusively, for the purpose of the Agency Workers Directive) I will provide accurate information.
20. I declare that the information given herein is true and complete and is not presented in a way intended to mislead. I agree that if I have, Access Healthcare may cease to offer me further agency placements without notice, as well as claim for recovery of any payments I have received, together with a claim for loss of profit to Access Healthcare.

Are there any fitness to practice issues with your registrations? Yes: ☐ No: ☐

Signed:	
Print name:	Date: