



APPLICATION FORM

Please complete this application form in block capitals and return with required documents.

Important Without all the relevant fields being completed and the application form signed we will not be able to fully process your application.

TITLE	SURNAME		INSERT PHOTO HERE	
PREVIOUS SURNAME				
FORENAMES				
DATE OF BIRTH	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE		
HOME ADDRESS				
POST CODE				
PREFERRED MEANS OF CONTACT				
HOME TEL NUMBER		MOBILE TEL NUMBER		
WORK TEL NUMBER		EMAIL ADDRESS		
CAR OWNER	<input type="checkbox"/> YES <input type="checkbox"/> NO	DRIVING LICENCE	<input type="checkbox"/> YES <input type="checkbox"/> NO	
WHERE DID YOU HEAR / SEE OUR DETAILS?				
<input type="checkbox"/> Medical Journal (which one (s))		<input type="checkbox"/> Referral (by who)		
<input type="checkbox"/> Search Engine (which one(s))		<input type="checkbox"/> Poster (where)		
<input type="checkbox"/> Promotional Literature/		<input type="checkbox"/> Other (how)		
LANGUAGES				
Written Language	Native		2 nd	3 rd
Spoken Language	Native		2 nd	3 rd
NEXT OF KIN				
Name				
Relationship				
Address (if different)				
Contact Telephone Number.	Day:	Mobile:	Other:	
PREFERRED AREAS OF WORK				
<input type="checkbox"/> Any	<input type="checkbox"/> South West England	<input type="checkbox"/> North West England	<input type="checkbox"/> Northern Ireland	
<input type="checkbox"/> Greater London	<input type="checkbox"/> East England	<input type="checkbox"/> North East England	<input type="checkbox"/> Wales	
<input type="checkbox"/> South East England	<input type="checkbox"/> Midlands	<input type="checkbox"/> Northern England	<input type="checkbox"/> Scotland	
GENERAL PRACTITIONER				
GMC number		Expiry date:		
Medical indemnity		Expiry date:		
REGISTERED PHYSIOTHERAPIST				
HPC Registration Number		Expiry date:		
Surname on Card:				
INDEMNITY COVER				
Do you belong to a professional body that provides indemnity cover?			Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Yes, which body?				
Membership Number:		Expiry date:		
Limit of indemnity cover (£):		Number of sessions per week:		
ADDITIONAL INFORMATION				

<p>Do you have any criminal convictions/cautions, spent or unspent? (Applicants are not entitled to withhold information about convictions which for other purpose are 'spent' under the provisions of Section 4 (2) of the Rehabilitation of Offenders Act (1974) (Exemptions) Amendments Order (1986), due to the nature of work for which you are applying) The post applied may also require you to apply for a CRB Disclosure N.B. A criminal record will not necessarily result in unsuccessful registration. The disclosed information will not be used unfairly and will be confidential.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Are you under suspension, investigation, disciplinary procedure or notice of potential dismissal from any professional body or current employer?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Have you ever been dismissed from a former post (Please elaborate on separate sheet if applicable)</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Are you eligible to work in the U.K.?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Do you belong to any other agencies? (If so which one?).....</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Are you MOD security cleared? (Please provide details) </p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Are you HMP security cleared? (Please provide details) </p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

Please could you carefully read and sign the Rehabilitation of Offenders declaration below.

Rehabilitation of Offenders Act 1974

The role of the Physiotherapist is exempt from the provisions of the Rehabilitation of Offenders Act 1974; therefore convictions that may be considered "spent" by most people, must still be disclosed by you; this also applies to cautions, even though you may not have been convicted. As part of our compliance with the Recruitment and Employment Confederation's Medical Division Code of Conduct, we are required to obtain and hold on file, this declaration.

You are required to disclose details of any criminal record. Please list your convictions and their dates below. You should also tell us if you're currently under investigation or awaiting trial for a criminal offence

This information will be taken into account where the offence is relevant to the post for which you are applying, therefore disclosure need not result in you being excluded from obtaining a position. The nature of work you are applying for is exempt from the provision of section 4(2) of the Rehabilitation of Offenders Act 1974 (Exceptions Order 1975). Applicants are therefore, not entitled to withhold any information about convictions, even if they are regarded as "spent" convictions under the provisions of this act. Failure to declare a conviction may require us to exclude you from our register or terminate an assignment if the offence is not declared but later comes to light.

I confirm that I have read and understood my obligations as detailed above and undertake to inform Med-Co Healthcare, in writing, should these circumstances change (including arrest or caution) in relation to any criminal offence.

Name: _____ HPC Number: _____

Signed: _____ Date : __/__/__

Have you been convicted of / cautioned for, any criminal offence? **YES / NO** (*Delete as required*).

DATE	OFFENCE	SENTENCE	COMMENTS

DOCUMENTS REQUIRED (Support relevant documents with your Application – Original or Copy)
<input type="checkbox"/> Med-Co signed Application Form
<input type="checkbox"/> Up-to-date Curriculum Vitae (detailing all employment positions to date)
<input type="checkbox"/> A copy of your HPC Certificate
<input type="checkbox"/> A copy of your CSP card (If applicable)
<input type="checkbox"/> A copy of your Medical Indemnity Insurance Certificate (If applicable)
<input type="checkbox"/> Health Declaration form (enclosed)
<input type="checkbox"/> Signed Terms of Business (enclosed)
<input type="checkbox"/> Copy of a Criminal Records Bureau Certificate
<input type="checkbox"/> Copy of your Passport (Please bring original to the interview)
*If you do not hold a full UK passport or are not a national of an EEA state, please provide documentary evidence of your right to work in the UK.
<input type="checkbox"/> Contact details of two clinical references
<input type="checkbox"/> A copy of your Hepatitis B certificate

EMPLOYMENT HISTORY (If not documented within your Curriculum Vitae)

Please could you provide details of your previous positions of employment

1)

- Name of employer:
- Address:
- E-mail
- Tel. Number:
- Position held:
- Duties/Experiences:
- Period of time position held : From..... To.....
- Reason for leaving:

2)

- Name of employer:
- Address:
- E-mail
- Tel. Number:
- Position held:
- Duties/Experiences:
- Period of time position held : From..... To.....
- Reason for leaving:

N.B. Please continue on an additional sheet if necessary

DETAILS OF REFEREES

Please could you provide the contact details of two clinical referees below

1)

- Name of employer:
- Position:
- Address:
- E-mail
- Tel. Number:
- Period of time this referee has known you: From..... To.....
- Relationship (e.g. colleague\employer\tutor etc.)

2)

- Name of employer:
- Position:
- Address:
- E-mail
- Tel. Number:
- Period of time this referee has known you: From..... To.....
- Relationship (e.g. colleague\employer\tutor etc.)

WORKING TIME DIRECTIVE OP – OUT AGREEMENT

If the Working Time Regulations 1998 apply to the engagement of the Temporary Worker, the regulations require that a workers average time must not exceed 48 hours per week unless the worker agrees in writing to exceed the limit. If you are prepared to work more that 48 hours per week, tick the box below as confirmation of your agreement to opt-out of the regulations in this respect, in the event that the regulations apply:

Yes I am prepared to work more than 48 hours per week.

You may cancel this at any time by giving a minimum of one months notice in writing

BANK / BUILDING SOCIETY DETAILS

By completing this section, you will also be authorising Med-Co (Healthcare) Ltd to pay your weekly earnings directly into the bank or building society stated below and agree to notify Med-Co (Healthcare) Ltd in writing of any changes to these details.

Bank Account/Payee Name		Sort Code	
Bank Building Society Name		Account Number	
Branch		Role Number (Building Society)	

DECLARATION FOR APPLICANTS

I certify I have answered the questions in Med-Co (Europe) Ltd application form truthfully and in full and that I am not aware of any physical or mental disability which may affect my working capacity.

I also understand that any false or incomplete statements either on my application to register and whilst providing medical services to Med-Co (Europe) Ltd may result in my removal from the Agency register. If any statements are found to be false whilst registered with Med-Co (Europe) Ltd I understand my registration may be terminated.

I give consent to be medically examined if necessary and understand that an opinion regarding my fitness for work will be provided by the Agency's nominated Occupational Health Organisation to Med-Co (Healthcare) Ltd. I also agree that the conditions of continued registration are that I complete a brief annual health questionnaire and continue to provide valid documentation relevant to this application.

I confirm that I am aware and will abide by current Good Medical Practice procedures in particular relation to candidates providing Primary Care Services in Prisons (search www.dh.gov.uk).

I also confirm that I am aware that it is the duty of any candidate infected, or the candidate who has reason to believe they may be infected with the HIV virus (search www.dh.gov.uk), to inform Med-Co (Europe) should my circumstances regarding this issue arise.

I confirm that I am aware of the Department of Health's communicable diseases (search www.dh.gov.uk) and Department of Health Guidelines on health clearance including and in relation to TB, Hepatitis B, Hepatitis C, Rubella, Varicella (chicken Pox). I agree to inform the Employment Business Independent Occupational Health Services Forward Vision in confidence should I have any reason to suspect that I may be at risk to patients or to other Health Care workers.

I agree not to assist in providing medical services in the area of a Health Authority / Primary Care Trust or similar organisation from whose Medical List I have been removed, unless that removal was at my own request.

I confirm I am aware of and will abide by any HPC / GMC performance monitoring processes that are currently in place or may be introduced in the future.

I understand that in this form I have supplied information which constitutes sensitive data, as defined in the Data Protection Act 1998 and give consent to Med-Co (Europe) Ltd to hold and process such data for the purposes of health and safety and Agency requirements. I also consent to such information being passed onto such persons as will be necessary for the purpose of assessing my suitability for work.

I confirm that I will comply with the current Health & Safety at Work Act. I have also read, understood and will abide by Med-Co (Europe) Ltd Terms of Engagement of Temporary (Locum) Workers and understand that I can obtain current versions via Med-Co (Europe) Ltd website or by contacting the Agency to request them at any time.

I agree to notify Med-Co (Europe) Ltd immediately, in writing, should any of my circumstances change.

PRINT NAME:		FORENAMES:	
SIGN:		DATE:	

I declare that I am prepared to proceed with the Med-Co (Europe) registration process at the standard level.

Signature: _____

Date: _____

Med-Co (Healthcare) Ltd and Med-Co (Nursing) Ltd are wholly owned subsidiaries of Med-Co (Europe) Ltd. Any undertaking and permissions given to one company shall apply as if it were given to any other or all of the other Med-Co companies.

