

[Type here]



Registered Nurse Application Form

Title	Address
First Name	
Known As	Town/City
Middle Name(s)	County
Last Name	Postcode
Maiden Name	Date moved to this address:
Gender	Email:
Male <input type="checkbox"/> Female <input type="checkbox"/>	
Date of Birth	Tel: Home
Nationality	Tel: Mobile
	How Did You Hear Of Us:

*** PLEASE ATTACH A LIST OF PREVIOUS ADDRESSES FOR LAST 6 YEARS - FORM ATTACHED**

Work Status	
Self Employed or PAYE	
National Insurance No	
Driving License	Yes <input type="checkbox"/> No <input type="checkbox"/>
Car Owner	Yes <input type="checkbox"/> No <input type="checkbox"/>

[Type here]

CAREER HISTORY

Please confirm your career history details for the last 10 years. Please list using most recent first.

Employer:			
Address:			
Phone number:			
Date started:		Date left:	
Job title:		Full or part time:	
Grade:		Dept/Ward:	
Reason for leaving:			

Employer:			
Address:			
Phone number:			
Date started:		Date left:	
Job title:		Full or part time:	
Grade:		Dept/Ward:	
Reason for leaving:			

Employer:			
Address:			
Phone number:			
Date started:		Date left:	
Job title:		Full or part time:	
Grade:		Dept/Ward:	
Reason for leaving:			

[Type here]

CAREER HISTORY cont.

Employer:			
Address:			
Phone number:			
Date started:		Date left:	
Job title:		Full or part time:	
Grade:		Dept/Ward:	
Reason for leaving:			

Employer:			
Address:			
Phone number:			
Date started:		Date left:	
Job title:		Full or part time:	
Grade:		Dept/Ward:	
Reason for leaving:			

Employer:			
Address:			
Phone number:			
Date started:		Date left:	
Job title:		Full or part time:	
Grade:		Dept/Ward:	
Reason for leaving:			

[Type here]

QUALIFICATIONS & TRAINING

Date Qualified:

NMC Pin Number:

Expiry Date:

Where did you train?:

Please give details of training undertaken and qualifications obtained:

You should supply any certificates such as ENB or Diplomas etc -please note that we require manualhandling/CPR certifications that have been updated in the last 12 months

BAND (NEW TERMINOLOGY) 1-8																				
2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6	<input type="checkbox"/>	7	<input type="checkbox"/>	8	<input type="checkbox"/>							
TYPE OF WORKER																				
RNLD		<input type="checkbox"/>	RHV		<input type="checkbox"/>	EN		<input type="checkbox"/>	RSCN		<input type="checkbox"/>	RFN		<input type="checkbox"/>	RM		<input type="checkbox"/>	RGN		<input type="checkbox"/>
RMN		<input type="checkbox"/>	RH		<input type="checkbox"/>	ENM		<input type="checkbox"/>	ENG		<input type="checkbox"/>	ENMH		<input type="checkbox"/>	RNMH		<input type="checkbox"/>			
RECORDABLE QUALIFICATIONS																				
RN1-1 st Level General Nursing												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
RN2-2 nd Level General Nursing (England & Wales)												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
RN3-1 st Level Mental Illness												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
RN4-2 nd Level Mental Illness (England & Wales)												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
RN5-1 st Level Learning Disabilities												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
RN6-2 nd Level Learning Disabilities (England & Wales)												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
RN7-2 nd Level Nurses (Scotland & Wales)												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
RNB-1 st Level Sick children												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
RN9-Fever Nurse												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
RN12-1 st Level Adult Learning												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
RN13-1 st Level Mental Nursing												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
RN14-1 st Level Learning Disability												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
RN15-1 st Level Children												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
MRM-Midwifery												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
HRHV-Health Visiting												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
SPAN-Special Practitioner Adult Nursing												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
SPMH-Special Practitioner Mental Health Nursing												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					
SPCN-Special Practitioner Children's Nursing												YES	<input type="checkbox"/>	NO	<input type="checkbox"/>					

[Type here]

SPLD-Special Practitioner Learning Disabilities	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPGP-Special Practitioner General Practice	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPCM-Special Practitioner Community Mental Health	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SCLD-Special Practitioner Community Learning Disabilities	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPCC-Special Practitioner Community Children's Nursing	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPOH-Special Practitioner Occupational Health	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPSN-Special Practitioner School Nursing	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
SPDN-Home/District Nursing with integrated nurse prescribing	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
V100-Independent Nurse Prescribing V100	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
V200-Extended Nurse Prescribing V200	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
V300-Extended/Supplementary Prescribing	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
TTTT-Lecturer/Practice Educator	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
MIDWIFES ONLY			
Practising	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Intention to practice completed (you cannot work without this as a Midwife)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Expiry Date:			
Mentor Name & Address:			

MEDICAL HISTORY

Have you ever suffered from any of the following:

Heart/Circulatory Illness/Hypertension	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Diabetes	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Asthma/Hay fever	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Bronchitis/Pneumonia/Pleurisy	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Epilepsy	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Headaches/Migraine	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Tuberculosis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Psychiatric Illness/Anxiety/Depression	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Dermatitis/Psoriasis/Eczema	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Back problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Recurrent infections	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Hepatitis/Jaundice	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you taking any prescription drugs?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

If you have answered yes to any of the above questions please give details on separate paper attached to the back of the application form.

Have you ever been vaccinated, immunized or tested for/against any of the Following?

[Type here]

Varicella	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Tuberculosis including BCG	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Heaf, Mantoux or Tine	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Rubella (German Measles)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Poliomyelitis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Hepatitis B	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Hepatitis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
HIV	YES	NO
Tetanus	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Typhoid	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Any Other Please State:	<input type="checkbox"/>	<input type="checkbox"/>

Have you been vaccinated against Covid -19?

Injection 1	Injection 2	Injection 3	Any further Covid injections?
Date:	Date:	Date:	Date:
If no, please explain why?			

[Type here]

Name Of Referee:	Place of Work
Position	
Work Address:	
Country:	Postcode:
Telephone Number:	Fax:
Email:	Mobile Phone:

Name Of Referee:	Place of Work
Position	
Work Address:	
Country:	Postcode:
Telephone Number:	Fax:
Email:	Mobile Phone:

ANY OTHER OR SPECIAL NOTES

[Type here]

DISCLOSURES

Rehabilitation of Offenders Act

Due to 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 (exemption order 1975). Applicants are therefore, not entitled to withhold information about convictions which for other purposes are 'spent' under the provisions of the act and in the event of employment. Failure to disclose such convictions could result in dismissal or disciplinary action. Any information given will be completely confidential and will be considered only in relation to an application for positions in which the order applies, and should be entered at the end of any particulars you give in support of your application.

A copy of our written policies is available upon request. A criminal record will not necessarily be a bar to obtaining a position.

Have you ever been convicted of a criminal offence?

YES NO

Do you have any spent or unspent criminal convictions or cautions?

YES NO

With an enhanced disclosure, under section 4.2 of the Rehabilitation of Offenders Act 1974 (exemption order), all previous cautions, warnings and convictions will always be detailed regardless of how long ago.

[Type here]

Any conviction, caution, reprimand will require a written statement of each and every event and how it does not affect your suitability for the role you are applying for.

Have you supplied additional information with this application for any spent/ unspent convictions, cautions or reprimands?

YES NO

Have you ever been involved in court proceedings?

YES NO

Please give any additional information which you think may be relevant in support of your application on a separate page.

DECLARATION

I confirm that the information I have provided in support of this application is complete and true and understand that knowingly to make a false statement could be a criminal offence.

Signature: _____

Date: _____

I consent to Ace 24 consultancy checking the details I have provided against the various data sources in order to verify my identity and process the application. These details may be recorded and used to assist other organizations for identity verification purposes such as the CRB, regulatory bodies such as NMC or GSCC.

Signature: _____

Date: _____

Ace 24 Consultancy retains the right to hold this application and any other data required to process this application (whether in the UK, European Union or elsewhere) and keep for as long as necessary in line with the data protection act.

Please send the completed application form to the following address: -Compliance Team

Ace 24 Consultancy Colchester
Business Centre 1 George Williams
Way Colchester
Essex CO1 2JS

[Type here]

ADDITIONAL INFORMATION/CHECKLIST

On receipt of a satisfactorily completed application form, Ace 24 Consultancy will provide/send the following:-

1. Assist you with your DBS application for an enhanced DBS.

Please bring this Application Form to your interview along with the following ORIGINAL documentation for us to view and take copies. Without this information we cannot progress with your application.

	Please Tick Boxes
NMC pin card and your statement of entry	<input type="checkbox"/>
Valid Passport	<input type="checkbox"/>
Valid Visa/Work Permit/Certificate of British Nationality (if applicable)	<input type="checkbox"/>
National Insurance Number Card	<input type="checkbox"/>
2 additional forms/proof of Identity & Address - (Driving Licence or copy bills etc.)Full	<input type="checkbox"/>
Immunisation record :	
Hep B	<input type="checkbox"/>
MMR 1	<input type="checkbox"/>
MMR 2	<input type="checkbox"/>
Varicella	<input type="checkbox"/>
Hep B (IVS) HBSAg	<input type="checkbox"/>
Hep C (IVS)	<input type="checkbox"/>
HIV (IVS)	<input type="checkbox"/>
Training Certificates including:	
Moving and Handling (practical)	<input type="checkbox"/>
BLS / ILS / ALS	<input type="checkbox"/>
Complaints Handling	<input type="checkbox"/>
Conflict Resolution (inc management of violence & aggression)	<input type="checkbox"/>
Fire Safety	<input type="checkbox"/>
Information Governance (including Caldicott Protocols and Data Protection)	<input type="checkbox"/>
Health & Safety at Work (including COSHH and RIDDOR)	<input type="checkbox"/>
Infection Control (including MRSA and C-Diff)	<input type="checkbox"/>
Lone Worker Training (if applicable)	<input type="checkbox"/>
Food Hygiene (if applicable)IV	<input type="checkbox"/>
Certificate (if applicable)	<input type="checkbox"/>
Full CV	<input type="checkbox"/>
Addresses covering the past 6 years and dates of residency	<input type="checkbox"/>
2 Passport size photos	<input type="checkbox"/>

[Type here]

GDPR

The information shall be used and referred for purposes of knowing, understanding, and validating the information in relation to the qualifications for which the applicant is applying for purposes of recruitment and if successfully recruited, for information keeping and administration of employment with the Human Relations Department of the Company.

The Company shall treat all personal information with the utmost confidentiality in line with the standards of data protection required by the EU General Data Protection Regulation (GDPR).

I consent to Ace 24 consultancy checking the details I have provided against the various data sources in order to verify my identity and process the application. These details may be recorded and used to assist for identity verification purposes such as the CRB, regulatory bodies such as NMC or GSCC.

I agree that all the information collected in this form is necessary, the gathering information about me, as the applicant for the job and for the position that I am applying for.

I agree

YES

NO

Signature: _____

Date: _____

Ace 24 Consultancy Ltd retains the right to hold this application and any other data required to process this application (whether in the UK, European Union or elsewhere) and keep for as long as necessary in line with the data protection act.

Thank you for choosing ACE 24

[Type here]



HEALTHCARE

Providing Quality Service