

Delta Nursing Agency Limited

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e-mail: deltanurses@aol.com
Web-site: www.delta-nursing.co.uk



**Please complete this application form and take it to your nearest branch.
You may register any time between 8.00am and 4.30pm Monday to Friday.**

**South of England Tel: 020 7703 7999 • North of England Tel: 0121 633 4249
24 HOURS A DAY, 7 DAYS A WEEK, 52 WEEKS A YEAR**

You will need to bring with you:

1. Passport or Birth Certificate for European Union Citizen
2. For Non-European Union Citizen, your passport must contain the following status:
 - 1) Indefinite leave
 - 2) Exceptional Leave to Remain
 - 3) Covering letter from the Home Office confirming status
 - 4) Work Dependent Stamp Holders
 - 5) Students must bring in their passport, enrolment slips, College letter and Student photo ID Card
3. Contact names and business address of two referees at management level for whom you have worked during the past two years.
4. Enhanced Disclosure from the Criminal Records Bureau (CRB)
5. Immunisation details and test results of Rubella, Varicella, TB, and Hepatitis B immunisation.
6. Certificates of training (ENB or National Board or any relevant Nursing Certificates)
7. Infection Control Certificate dated within the last twelve months*
8. CPR and Manual Handling Certificates dated within the last twelve months
9. Full bank details and National Insurance Number
10. Proof of RCN/RCM/Unison Membership to offset/cover liabilities incurred during practice
11. NMC Pin Card and Statement of Entry for qualified/trained nurses
12. Certificates of Control & Restraint dated within the last twelve months* for those who wish to perform Nursing or Care for the Mentally Ill
13. Driving Licence (if available)
14. Background History from age 11 to date (C.V.)

IT IS A REQUIREMENT OF THE AGENCY THAT YOU ARE ABLE TO READ, SPEAK AND UNDERSTAND THE ENGLISH LANGUAGE.

*If your certificates need updating, Delta runs courses in these subjects and you can book a place on these courses to speed your registration. For further information, visit our website www.delta-nursing.co.uk

PLEASE ENSURE YOU BRING ALL REQUESTED DOCUMENTATION WITH YOU WHEN YOU COME TO REGISTER. OUR CONSULTANTS WILL NOT BE ABLE TO REGISTER YOU WITHOUT THEM.

DECEMBER '04

Please read this application form carefully before completing. PLEASE PRINT IN BLOCK LETTERS USING A BLACK BALL POINT PEN. Please complete all sections of the application form to ensure you provide all of the information requested.

PERSONAL DETAILS

Position Applied For			
Surname	Forenames	Maiden Name	Mr/Mrs/Miss/Ms
Address	Telephone Number (Home)	Mobile	Own Transport Yes <input type="checkbox"/> No <input type="checkbox"/>
	Post Code	Next of Kin Name:	Address: Telephone:
Date of Birth	Age:	NI Number:	NMC Pin Number (Qualified Nurses)
Nationality	Have you got permit to work in the United Kingdom? YES <input type="checkbox"/> NO <input type="checkbox"/>		

EDUCATION (Please give details of education from age 11)

PRIMARY EDUCATION

Name of School	City / Country	Dates		Grades obtained	Age on completion
		From	To		

SECONDARY EDUCATION

Name of School	City / Country	Dates		Grades obtained	Age on completion
		From	To		

COLLEGE & UNIVERSITY EDUCATION

Name of School	City / Country	Dates		Grades obtained	Age on completion
		From	To		

PROFESSIONAL MEMBERSHIP AND REGISTRATION

Organisation	Registration	Expiry / Renewal date

MIDWIVES

Practising	Yes <input type="checkbox"/> No <input type="checkbox"/>	"Intention to Practice" form filled	Yes <input type="checkbox"/> No <input type="checkbox"/>
Your Mentor's Name		Your Mentor must be one of your referees	

REFERENCES

Please give names and addresses of two referees, at least one reference must be your present or last employer, who is in a position to comment on your work experience and suitability for the post to which you have applied. This must be a manager or Supervisor.

If you have not been employed and/or never worked or you have not worked for some time you could provide the name of a head teacher or course tutor, supervisor or coordinators of school and college work experience placements and/or any voluntary work.

Please do not give names of family members or friends. Note that the references you provide should have direct relationship with your work and/or life history.

REFERENCES - CONTINUED

REFERENCE ONE

Name

Work Title

How known to you

From To

Address

Post Code

Telephone

REFERENCE TWO

Name

Work Title

How known to you

From To

Address

Post Code

Telephone

Please note, references will be taken up prior to deployment for shifts and before commencing work. Delta Nursing Agency Limited expects that you had the work experience and qualifications that you have stated in your application.

EMPLOYMENT HISTORY

(NOTE: if you were looking after children or self-employed, please state)

Current job title or last job: _____

Name of Organisation: _____

Address: _____

Telephone: _____

Postcode: _____

Fax Number: _____

Main responsibilities: _____

Dates from: _____

To: _____

Reasons for leaving: _____

Supervisor/Manager's Name: _____

Salary: _____

Per annum/month/week/hour

PREVIOUS EMPLOYMENT IN DATE ORDER

(Please begin with the most recent first-Include work you did through agencies)

Employer's Name and Address	Dates		Job title of post held	Grade	Reason for leaving
	From	To			

Have you ever been dismissed from employment, faced disciplinary action or awaiting disciplinary hearing/investigation? YES

NO

APPLICANT SKILL PROFILE

H.C.A.'S AND CARE WORKERS ONLY

Full Name

Speciality

Date

Grade

PERSONAL HYGIENE

	1	2	3	4
Bath, shower, assisted wash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of bath aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth care (inc. dentures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of feet (exc. toenails)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing / undressing of patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bed Bath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of fingernails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TOILETING

	1	2	3	4
Use of bedpans / commodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recording fluid balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emptying a catheter bag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of incontinent patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MOBILITY

	1	2	3	4
Lifting / Transferring patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of walking aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of hoists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting / handling course (written evidence required)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OBSERVATION

	1	2	3	4
Temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LEVEL OF COMPETENCE - Please tick ✓ the box in accordance with your level of expertise as indicated below:

1. I am familiar with this procedure and can perform independently.
2. I am familiar with this procedure but would need supervision.
3. Understand theory behind procedure, but never performed task.
4. No contact with the equipment or this situation. No knowledge of procedure.

NUTRITION

	1	2	3	4
Preparation of meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding a dependant patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GENERAL

	1	2	3	4
Pressure area care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing of personal laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bedmaking: changing a bed or drawer-sheet with patient in / on it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of terminally ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHERS

	1	2	3	4
Maintaining client confidentiality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Report writing / giving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Observe changes in patient / client's condition and report to person in charge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EXPERIENCE

	YES	NO
Hospital	<input type="checkbox"/>	<input type="checkbox"/>
Nursing Home	<input type="checkbox"/>	<input type="checkbox"/>
Hospice	<input type="checkbox"/>	<input type="checkbox"/>
Patient with dementia	<input type="checkbox"/>	<input type="checkbox"/>
First aid	<input type="checkbox"/>	<input type="checkbox"/>

TRANSPORT

	YES	NO
Do you have a current Full UK Driving Licence	<input type="checkbox"/>	<input type="checkbox"/>
Do you own or have access to a motor vehicle	<input type="checkbox"/>	<input type="checkbox"/>

Other Skills / Comments

Signed

Date

APPLICANT SKILL PROFILE

QUALIFIED NURSES ONLY (continued)

WOUND CARE

	1	2	3	4
Changing wound dressings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aseptic technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Removal of sutures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drain dressings (e.g. keyhole - redivac and closed drainage system)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change of vacuum bottle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortening of a drain (e.g. Penrose, Corrugated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Removal of drain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prevention of pressure sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY

	1	2	3	4
Oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suctioning oropharyngeal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
endotracheal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tracheostomy care changing a dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
suctioning a tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
changing a tracheostomy tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing of chest tubes (under water seal drainage)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changing drainage tubing and bottles (under water seal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Removal of drainage tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of ventilated patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtaining arterial blood gases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpreting arterial blood gases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assisting with intubation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR

	1	2	3	4
Perform 12 lead electrocardiograms (ECG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	1	2	3	4
Telemetry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation of basic arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiopulmonary resuscitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Defibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assisting with insertion of a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aortic balloon pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swans-Ganz catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient with acute myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient with congestive cardiac failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient post cardiac surgery (e.g. coronary vein grafts, aortic valve replacement)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient post cardiac catheterisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CARDIAC ARREST

	1	2	3	4
Knowledge of drugs used	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of airway and ambu bag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac compressions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHERS

	1	2	3	4
Barrier nursing - infectious or immunosuppressed patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of multiple trauma patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient with eye problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of confused patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge of the UKCC Code of Professional Conduct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge of the UKCC guidelines for the administration of medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Skills / Comments

Signed

Date

APPLICANT SKILL PROFILE

QUALIFIED NURSES ONLY

Full Name

Speciality

Date

Grade

ADMINISTRATION OF MEDICINES

	1	2	3	4
Oral administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of rectal and vaginal preparations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Topical application of drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of drugs in other forms e.g. eye, ear, nose drops, inhalations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cytotoxic drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INTRAVENOUS THERAPY

	1	2	3	4
I.V. Rate calculations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Admission of drugs by continuous infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Admission of drugs by intermittent infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Admission of drugs by direct injection e.g. bolus or push	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heparinization of IV Cannula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of blood and blood products e.g. plasma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infusion pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syringe drivers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Central venous catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Central venous pressure readings (CVP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Venepuncture (taking blood)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arterial lines: setting up for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
taking a blood sample from	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
removal of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TOTAL PARENTAL NUTRITION

	1	2	3	4
(TPA Hyperalimentation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge of solutions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assistance with insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL

	1	2	3	4
Naso-gastric tube insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of naso-gastric tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding via naso-gastric tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stoma Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of the patient with abdominal wounds/drains e.g. gastrostomy, PEG tube, caecostomy drain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of a patient undergoing abdominal paracentesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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CARE OF PATIENT DURING AND AFTER A LIVER BIOPSY

	1	2	3	4
Care of a patient during and after a liver biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of a patient post abdominal surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of enemas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of suppositories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal lavage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RENAL

	1	2	3	4
Insertion of catheter Male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catheter care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suprapubic catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nephrostomy tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder lavage and irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of a patient with renal transplant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
on haemodialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
on peritoneal dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
following nephrectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL

	1	2	3	4
Neurological observations and assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of a patient during & following a seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of patient with a head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
following a cva	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
with a spinal cord injury (e.g. quadraplegic/ paraplegic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
following spinal injury (e.g. laminectomy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
an unconscious patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during or after a lumbar puncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ORTHOPAEDICS

	1	2	3	4
Care of a patient in plaster of Paris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
with skin traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
with skeletal traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
following amputation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Halo traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crutchfield tongs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stryker frame	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal lifts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg rolls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH DECLARATION

All members are required to complete this Health Declaration. Any positive answers will not necessarily affect your application.

General Practitioner or Occupational Health Department

Address

Tel. No

Post Code

MEDICAL HISTORY

Have you ever been treated at a hospital for serious illness or surgery? *(Please give dates)*

Yes

No

Details

How much time have you lost from work due to illness in the last five years? *(Please provide details)*

Are you a registered disabled person?

What is the date of your last chest x-ray?

Have you ever suffered from any of the following?

Yes

No

Details

Heart/Circulatory Illness/Hypertension

Diabetes

Asthma/Hayfever

Bronchitis/Pneumonia/Pleurisy

Tuberculosis

Epilepsy/Frequent Fainting Attacks

Headaches/Migraine

Psychiatric Illness/Anxiety/Depression

Dermatitis, Skin Sensitivity (Allergies) Psoriasis/Eczema

Back Injury/Back Problems or Back Pains

Recurrent Infections e.g. Sore Throats/Ear Infections

Hepatitis/Jaundice

Are you receiving Medicines, Pills or Tablets from a Doctor or on Prescription?

Yes

No

Details

Do you have any other physical disabilities other than those listed above that could affect your ability to carry out your assignment?

Have you ever been Vaccinated, Immunized or Tested for/against any of the following?

Yes

No

Details

Varicella

Tuberculosis including BCG

Heaf, Mantoux or Tine

Rubella (German Measles)

Poliomyelitis

Hepatitis B

Hepatitis B Antibodies Date & Result

HIV

Tetanus

Typhoid

Any Other

Please enter your height and weight

Height

Weight

Do you Smoke?

Yes

No

I declare that the statements are true and complete to the best of my knowledge and belief. I understand that my General Practitioner may be consulted with my prior consent.

Signed

Date

DECLARATION

I understand that any offer of employment is subject to health clearance, Enhanced CRB Disclosure and confirmation of statutory qualifications/registration if applicable.

I certify that the information given on this form is correct and understand that any misleading statements or deliberate omissions will be regarded as grounds for withdrawal of offer or subsequent disciplinary action, which could result in dismissal.

I understand that the information will be entered on to our computer database under the terms and conditions of the Data Protection Act 1998 and will be treated in a secure and confidential manner.

I have read and understood the DELTA NURSING AGENCY LIMITED OPT-OUT OF 48-HOUR WORKING WEEK AGREEMENT as described in the terms and conditions of Engagement and I hereby consent that the working week limit shall not apply to my assignments in accordance with paragraph 3 of the agreement. I understand that under paragraph 4, WITHDRAWAL OF CONSENT, I can end this agreement by giving the Employment Business 14 days notice in writing.

Signed

Date

REHABILITATION OF OFFENDERS ACT

Because of the nature of the work for which you are applying, this post is exempt from the provisions of Section 2.4 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, any 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 to 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 on request. A criminal record will not necessarily be a bar to obtaining a position.

PLEASE GIVE ANY ADDITIONAL INFORMATION WHICH YOU THINK MAY BE RELEVANT IN SUPPORT OF YOUR APPLICATION
(Continue on a separate sheet if necessary)

REGISTRATION VALIDATION - FOR OFFICE USE ONLY

	Yes	No		Yes	No
1. CRB Check Countersigned	<input type="checkbox"/>	<input type="checkbox"/>	6. Completed & signed health check (including Doctor's name & address)	<input type="checkbox"/>	<input type="checkbox"/>
2. Full face to face interview	<input type="checkbox"/>	<input type="checkbox"/>	7. Keywording complete	<input type="checkbox"/>	<input type="checkbox"/>
3. Copy of Passport or Birth Certificate if British/EU National	<input type="checkbox"/>	<input type="checkbox"/>	8. 48 hour opt out	<input type="checkbox"/>	<input type="checkbox"/>
4. Statement of Entry	<input type="checkbox"/>	<input type="checkbox"/>	9. Candidates written and spoken English checked	<input type="checkbox"/>	<input type="checkbox"/>
5. Signed Contract of Employment	<input type="checkbox"/>	<input type="checkbox"/>	10. Delta Reference Number	<input type="checkbox"/>	<input type="checkbox"/>
			11. Photograph submitted	<input type="checkbox"/>	<input type="checkbox"/>

ITEMS REQUIRING RENEWAL OR UPDATE

	Yes	No	
1. Work Permit	<input type="checkbox"/>	<input type="checkbox"/>	Expires <input type="text"/>
2. CRB Reference No:	<input type="checkbox"/>	<input type="checkbox"/>	Expires <input type="text"/>
3. Manual Handling	<input type="checkbox"/>	<input type="checkbox"/>	Expires <input type="text"/>
4. CPR Update	<input type="checkbox"/>	<input type="checkbox"/>	Expires <input type="text"/>
5. Hep B Immunisation	<input type="checkbox"/>	<input type="checkbox"/>	Expires <input type="text"/>
6. RCN/RCM/Unison Insurance	<input type="checkbox"/>	<input type="checkbox"/>	
Membership No: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expires <input type="text"/>
7. NMC Pin	<input type="checkbox"/>	<input type="checkbox"/>	Expires 31 st March 20.....
8. Midwives Intention to Practice	<input type="checkbox"/>	<input type="checkbox"/>	Expires <input type="text"/>
9. Advanced Life Support	<input type="checkbox"/>	<input type="checkbox"/>	Expires <input type="text"/>
10. Paediatric Advanced Life Support	<input type="checkbox"/>	<input type="checkbox"/>	Expires <input type="text"/>
11. Aggression Awareness	<input type="checkbox"/>	<input type="checkbox"/>	Expires <input type="text"/>
12. Induction - Health & Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

FOLLOW-UP PROCESSES

DATES

DATES

Verbal References	1. <input type="text"/>	2. <input type="text"/>
Written Request	1. <input type="text"/>	2. <input type="text"/>
Request Received	1. <input type="text"/>	2. <input type="text"/>
NMC Verbal Confirmation	Date <input type="text"/>	
NMC Written Confirmation	Date <input type="text"/>	

COMPLETE SIGN OFF

I confirm that I have interviewed this candidate in accordance with the registration requirements set out by Delta. I am satisfied that he/she can be cleared for work.

Signature of Consultant

Name of Consultant

Date

NUMERICAL INTERVIEW ASSESSMENT