



Dear Doctor,

Thank you for your enquiry regarding locum work. Enclosed you will find everything that you will need to register with us.

In order for us to process your application and to enable us to begin looking for work for you as soon as possible, could you please ensure that you enclose the following documentation.

Application Pack

Application form	completed & signed	<input type="checkbox"/>	
Updated CV		<input type="checkbox"/>	
References		<input type="checkbox"/>	
Eligibility to work		<input type="checkbox"/>	Passport / Visa / Other
Enhanced CRB		<input type="checkbox"/>	
GMC Certificate		<input type="checkbox"/>	
PCT Inclusion		<input type="checkbox"/>	
Other Qualification Certificates:			
Basic Life Support Training		<input type="checkbox"/>	
Child Protection Training		<input type="checkbox"/>	
Infection Control Declaration		<input type="checkbox"/>	
JCPTGP Certificate / Letter of Entitlement		<input type="checkbox"/>	
Professional Indemnity Insurance Policy		<input type="checkbox"/>	
Ltd Co Certificate of Incorporation if applicable		<input type="checkbox"/>	
2 x passport-sized photos		<input type="checkbox"/>	

Health Pack

Pre-Employment Health Questionnaire	<input type="checkbox"/>
Immunisation (less than 5 years old)	
TB Declaration	<input type="checkbox"/>
MMR	<input type="checkbox"/>
Hep B Serology	<input type="checkbox"/>
Hep C test	<input type="checkbox"/>
Rubella Cert / Serology	<input type="checkbox"/>
Varicella	<input type="checkbox"/>

Once your application form and documents have been received, we will contact you to discuss your specific requirements. In the meantime, if you require clarification about any of the documents that we have asked you to provide, or have any other queries, please again do not hesitate to contact us.

Kind Regards

Nikki Kaur
Locum Coordinator

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Mob: 07545 427 050
Fax: 0121 212 3611
Email: nikki.kaur@primecare.uk.net

Part of the Nestor Healthcare Group PLC
A National Framework Compliant Agency

PERSONAL DETAILS

<input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms Surname	First Name(s)	
Speciality	Grade	
Date of Birth	Nationality	
Marital status		
Current address		
	Post Code	
Telephone No/s Home	Work	Bleep
Mobile	E-mail address	
Permanent address <i>[if different from above]</i>		
Post Code		
Car owner in UK <input type="checkbox"/> YES <input type="checkbox"/> NO	Drivers Licence <input type="checkbox"/> YES <input type="checkbox"/> NO	
Next of kin	Relationship	
Contact address		
Post Code	Telephone No	

We need to be able to confirm your identity - please indicate the original form of identity that you will provide

Passport / Birth Certificate

ELIGIBILITY TO WORK IN THE UK

Passport Number	Passport Expiry Date
Visa Status	<input type="checkbox"/> Not Required <input type="checkbox"/> Indefinite Leave <input type="checkbox"/> Work Permit <input type="checkbox"/> Student
Visa Number	Visa Expiry Date

DISCLOSURE

I already have an 'Enhanced' CRB Disclosure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Disclosure Number*	Date Issued*
Name of Employer*	(*This information can be found on your current Disclosure)
I wish to apply for a new Disclosure <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, Request to be sent a Disclosure Pack



PROFESSIONAL INDEMNITY INSURANCE

We would like to remind you of the limits of the indemnity available under crown indemnity and would advise you of the availability of personal professional indemnity insurance. If you wish to work outside of the NHS, PI Insurance is a pre-requisite.

If you have already arranged cover then please supply us with the following information

Name of insurer

Policy Number

Expiry Date

I confirm that it is my responsibility to ensure at all times that my indemnity insurance is valid and up to date to work in any position I accept through your Company

SIGNED

PROFESSIONAL QUALIFICATIONS (f)

GMC Registration Number

Expiry Date

Type of Registration (delete as applicable)

Eligible Limited Full

Specialist Registrations (if applicable)

Do you have any limitations to practice

YES NO

If yes please give details

Have you ever been, or are you currently suspended from practicing

YES NO

If yes please give details

Are you aware of any professional enquires undertaken following allegations made against you in the UK or abroad, which may have a bearing on your suitability for this post?

YES NO

If yes, please give details.

Section 12 Approval - Mental Health Act (if applicable)

YES NO

Other relevant Professional Qualifications

General Practitioners

Eligibility to practice

JCTPGP Registration / Acquired Rights

Inclusion on the Performers list

Name of PCT

Date of Registration

Number

I hereby confirm that there have been no changes to the above registration since the date of registration. There are no matters in relation to the GMC, NCAA or PCT of which I am aware of, or which is either outstanding or of which I have notice of that in any way affects the registration.

Name (Please print)

Signature

Date

EMPLOYMENT HISTORY & REFERENCES (j)

Name of Current / Most Recent Employer	
Date of employment from	to
Grade	Speciality
Name of Referee	Position of Referee
Contact Telephone	Contact email
Do we have permission to contact the referee	<input type="checkbox"/> YES <input type="checkbox"/> NO

Name of Previous Employer	
Date of employment from	to
Grade	Speciality
Name of Referee	Position of Referee
Contact Telephone	Contact email
Do we have permission to contact the referee	<input type="checkbox"/> YES <input type="checkbox"/> NO

PAYMENT STATUS & BANK DETAILS (k)

PAYE (if applicable)	NI Number
Ltd Company (if Applicable)	Ltd Company Name
Bank Account Name	Bank Account Number
Bank Account Sort code	Bank Account Address

DATA PROTECTION ACT (m)

Under the Data Protection Act 1998 ("The Act") we are required to provide you with certain information and to seek your consent to the processing of personal data supplied by you on this form.

For the purposes of the Act the data controller in respect of personal data relating to you is Nestor Healthcare Group plc. The purposes for which personal data supplied by you on this form are intended to be processed are as follows: -

- To assess your skills, suitability and eligibility for membership
- If you subsequently become a member to assist in introducing you to our clients
- To update you with relevant information pertaining to your membership

The personal data supplied by you on this form may be also disclosed to other approved third party companies in order to inform you of training courses and additional benefits. Pick tick if you do not wish to be supplied with this information.

We may retain certain personal data supplied by you on this form after you have ceased to be a member in order to comply with current legislation and client requirements.

I consent to the Company processing all or any personal data supplied by me on this form, and to the disclosure and transfer of such personal data and supporting documentation to 3rd parties for the purposes described above.

Name (please print)

Signed _____ Date _____

WORKING TIME DIRECTIVE DECLARATION (n)

Regulation 4 of the Working Time Directive requires that a worker's average time must not exceed 48 hours per week unless the worker agrees in writing to exceed the limit. If temporary employees are to lawfully work more than 48 hours they must sign an opt-out agreement to this effect. If you are prepared to work more than 48 hours per week please sign the declaration below in order that we employ you legally should your hours exceed 48 per week. You may withdraw from this agreement by giving us one month's written notice.

Name (please print) _____

Signed _____

Date _____

REHABILITATION OF OFFENDERS DECLARATION (o)

Have you ever been convicted of a criminal offence or cautioned or do you have any hearings pending YES NO
If 'YES' please give further information

Under the Rehabilitation of Offenders Act 1974 (from which the healthcare industry is exempt) you are required to reveal all convictions. This has to include ALL spent convictions as defined under the Act. We actively promote equality of opportunity for all, as stated in its Equal Opportunities policy, which can be found in your handbook or at your local office. If you are in any doubt whatsoever about a declaration, you must discuss this with your local office Manager. A conviction does not automatically prevent you from registering, however failure to declare, will lead to immediate action. You are required to inform us if you are convicted of a criminal offence, cautioned or have a hearing pending IN THE FUTURE.

Declaration

I have completed an application for a Criminal Records Bureau Disclosure / Portability Consent Form and can further state that to the best of my knowledge and belief, there will not be any positive disclosure made.

I also give permission for a copy of the disclosure to which I am subject being made available, upon written request, to a named Authorised person, who acts on behalf the National or Local Government for auditing purposes.

I hereby authorise the company to deduct or collect the relevant fee, as laid down by the Criminal Records Bureau, for the purpose of collecting the Disclosure Fee only.

Name (please print) _____

Signed _____

Date _____

APPLICATION DECLARATION (p)

I have read, understood and agree to abide by the policies of the Terms and Conditions of Service. I confirm the above information is complete, correct and true to the best of my knowledge and will notify you immediately should there be a change in circumstances.

I will give immediate notification of any proceedings or investigations in the future, to which I am subject by any professional, regulatory or criminal body or similar organisation.

Name (please print) _____

Signed _____

Date _____

CONDITIONS OF SERVICE

These Terms and Conditions constitute a legally binding agreement between you and (the Company). It is a condition of service that you read and fully understand these conditions. We will be pleased to clarify any points you do not understand.

1. The Role of the Company

The Company acts as an agent for each and every locum registered. You are not an employee of the Company. Nothing in these conditions creates such a relationship and (to the exclusion of the Company) you will be under the direction, supervision and control of the client throughout the duration of your assignment. The Company is not competent to and will not give you any directions or instructions as to the manner in which you should perform your duties throughout the period of your assignment.

2. Locums Employment Status

Locums are self-employed in all cases. In appropriate cases, PAYE tax deductions will be made from your pay and the Company will collect national insurance contributions from both the client and you. Because locum 'contracts' exist only for the period of each duty and do not exist should locums be unavailable for work for any reason or if there is no suitable work available, you have no entitlement to statutory sick pay. You should make enquiries of your local dept of social security office with regard to sickness benefit. You must provide the Company with your NI number. If you do not have such a number you should apply for one through your local office of the dept of social security. If you have more than one job you may be able to claim deferment of NI by authorising the Company not to deduct NI from your pay. To apply for deferment contact your local dept of social security office. If you are not a UK resident, it is your responsibility to ensure you have the right to work in the UK, and that you obtain the appropriate written consent.

3. Appointments

The Company makes every effort to find Locum suitable employment but will make no guarantee that we shall always be able to do this. Work appointments are made in accordance with the terms of this agreement and the terms of business (available on request). You must keep any appointments or arrangements that are made for you. If you are unable to report for duty for any reason whatsoever you must telephone the appropriate division immediately so that every effort can be made to find a replacement. If for any reason you are delayed and will be late for an assignment for which you have been placed, the Company must be informed immediately of the delay so that the client may be advised. This may result in the client cancelling your assignment without compensation.

If for any reason a client or another agency approaches you with further sessions at a service where you were last represented by Primecare Locums then you must inform the relevant consultant at Primecare Locums who will arrange the sessions on your behalf.

4. References and Documentation

You must provide evidence of your professional registration or enrolment with the appropriate registration body for your profession. The Company will obtain professional references on you. The Company reserves the right to submit all or any part of the information contained in such references to its clients.

5. Payment and Timesheets

The Company makes payment to you in advance of fees earned by them, and you irrevocably appoint the Company as their agent to prepare and submit accounts and collect and recover fees, expenses, charges and extras in the name of the Company. The commission due will be deducted from the monies received from the client. All assignments must be booked through the Company and will subject to agency fees. You will be required to complete timesheets in respect of each assignment. The timesheet prepared by you must be returned to the Company. Late submission of timesheets after assessments may result in payment being delayed. To fulfil our record keeping obligation, hours worked will continue to be monitored on a timesheet basis.

6. Incidental Expenses

Except where you are advised to the contrary, throughout the period of your assignment you are responsible for meeting the cost of your own meals, telephone calls and accommodation. Allowances toward travel expenses must be agreed at the time of confirmation of the booking as this varies from client to client and is at their discretion.

7. Standards of conduct

You are required at all times to maintain the highest professional standards and you are also required to work to the policies, procedures and requirements of the clients workplace and comply with the codes of conduct of any professional organisation to which you belong.

8. Communication with the Company

The Company must be notified immediately in writing of changes of address, telephone number or bank details. This ensures you have access to the greatest selection of assignments.

9. Cancellation

Clients may cancel an assignment at short notice and in such circumstances the Company cannot accept responsibility or liability for any loss of expense, which may be suffered by you as a result of such cancellation.

10. Professional Indemnity Insurance

It is a condition of registration with the Company that you have appropriate professional indemnity cover. You are responsible for all your acts or omissions during the course of your assignment with the clients and the Company can accept no responsibility for any loss or claim that might arise out of or in connection with your introduction to a client. Lack of personal professional indemnity Insurance cover may restrict the range of work available to you.

11. Termination of service

You may terminate your registration with the Company at any time, but one weeks notice must be given.

12. Health and Safety

As a self-employed person, you have a personal responsibility to regard health and safety policies and fully co-operate with those in charge of the workplace. You are required to assess for any risks in the workplace and maintain a safe environment both for yourself, other staff and clients. You are also requested to report any communicable diseases to the Company Manager, even following termination of contract. This enables the Company to fulfil it's obligation under RIDDOR (Reporting of Injuries and dangerous occurrences regulation 1995) to protect both client and staff health and safety, whilst maintaining optimum confidentiality to all its assessors.

13. Negligence

If you are removed from a case or a complaint for misconduct or professional negligence is received, the Company reserves the right to withhold payment in advance of fees earned by you.

14. Data Protection

In accordance with the data protection act 1998, the information you have provided on your application form is used to inform you of potential work opportunities. We may use this data to keep you informed of the latest healthcare developments, legislation and policy changes and company initiatives.

Any sensitive information such as racial or ethnic origin, religious beliefs, health, passport and criminal records are for monitoring and selection purposes only, however, from time to time it may be necessary to forward sensitive details relating to your passport and CRB. By signing these conditions of service you are permitting us to use this information in this way.

Signature _____

Date _____



Pre-employment Confidential¹ Declaration of Medical History.

Please provide details of your medical history by answering the following questions. Please tick one box in answer to each question, and be sure to answer every question.

Surname: _____
Forename(s): _____
Previous Name: _____
Address: _____
Postcode: _____
Home Telephone: _____
Work Telephone: _____
Email: _____
Date of Birth: _____

Your General Practitioner's details

Name: _____
Practice address: _____
Specialty Applied for: _____
Grade: _____

¹ The purpose of this questionnaire is to ensure that your employer is aware of any health issues which may be relevant to your employment. We need to ensure that you are fit to undertake the duties of the position for which you have applied, and that any relevant health issues can be addressed and if necessary, accommodated with reasonable adjustments. If you need more space to provide details, please use the space provided at the end of this form.

A. GENERAL HEALTH

		YES	NO
1	Do you consider yourself to be in good health?	<input type="checkbox"/>	<input type="checkbox"/>
2	Are you receiving any regular medication or regular attention from your GP or at hospital?	<input type="checkbox"/>	<input type="checkbox"/>
3	How many days were you away from work due to illness in the last twelve months?	[] []	days

If the answer to 2 is 'Yes', please provide brief details here:

Your Name:

Date of Birth:

B. PREVIOUS MEDICAL ILLNESSES

Do you, or have you ever suffered from any of the following problems? Please tick one box on each line.

		YES	NO
1	Heart or circulation problems?	<input type="checkbox"/>	<input type="checkbox"/>
2	Back pain, neck pain, joint problems or arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
3	Any blackouts, disabling giddiness, fainting attacks, or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
4	Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5	Stress, anxiety, depression or other psychiatric disorder?	<input type="checkbox"/>	<input type="checkbox"/>
6	Problems with alcohol or drug misuse?	<input type="checkbox"/>	<input type="checkbox"/>
7	Speech, hearing or visual difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
8	Skin condition?	<input type="checkbox"/>	<input type="checkbox"/>
9	Asthma, wheezing or allergic condition?	<input type="checkbox"/>	<input type="checkbox"/>
10	Any important medical conditions not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>
11	Are you pregnant??	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered 'YES' to any of the above questions please give details in this box:

² For the purposes of this Occupational Health assessment, this question is asked to ensure only that any health needs of pregnancy are addressed, and to avoid any hazard or risk to a developing baby.

C. HEALTH PROBLEMS IN PREVIOUS EMPLOYMENT(S)

		YES	NO
1	Has any previous work had a detrimental effect on your health?	<input type="checkbox"/>	<input type="checkbox"/>
2	Have you left or been retired from a previous job because of ill health?	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered 'YES' to any of these questions, please give details in this box:

D. DISABILITY

		YES	NO
1	Have you ever been registered or judged as being disabled?	<input type="checkbox"/>	<input type="checkbox"/>
2	Do you have an impairment which might qualify under the Disability Discrimination Act 1995?	<input type="checkbox"/>	<input type="checkbox"/>
3	Have you left or been retired from a previous position due to a disability?	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered 'YES' to any of the above questions, please give details in this box:

Your Name: _____

Date of Birth: _____

E. RECORD OF IMMUNITY

All Applicants must indicate 'Yes' or 'No' to all parts of Questions 1-5.
Applicants undertaking EPP⁵ must also indicate 'Yes' or 'No' to Questions 6-8

Disease			YES	NO	Please provide details	
1	Tuberculosis	i	Have you had a BCG (TB) vaccination? ¹	<input type="checkbox"/>	<input type="checkbox"/>	All Applicants must arrange to have the attached TB Evidence Form completed (unless TB serology attached).
		ii	Have you ever been treated for TB?	<input type="checkbox"/>	<input type="checkbox"/>	
		iii	Have you had a tuberculin skin test? ³	<input type="checkbox"/>	<input type="checkbox"/>	Year:
		iv	Have you visited, or arrived from a country outside the UK in the last 12 months? ⁴	<input type="checkbox"/>	<input type="checkbox"/>	Result: Date from: to: Country: Holiday/Work (delete as applicable)
		v	In the past 12 months, have you had an unexplained cough for more than 3 weeks, fever or loss of weight?	<input type="checkbox"/>	<input type="checkbox"/>	
		vi	In the last 2 years, have you had a Chest x-ray? If so, when, where and what was the result?	<input type="checkbox"/>	<input type="checkbox"/>	If 'Yes', you must provide a copy of the result.
2	Hepatitis B	You must attach evidence of your Hepatitis B immunity status.	<input type="checkbox"/>	<input type="checkbox"/>	All clinicians must supply evidence of HbsAb. If the result is <100iu, further testing may be needed to exclude infection.	
3	Varicella (Chickenpox)	Have you had chickenpox or shingles?	<input type="checkbox"/>	<input type="checkbox"/>	If "No", please provide a copy of evidence of immune status.	
4	MRSA	Are you aware of the need to co-operate with screening in the event of an outbreak of MRSA?	<input type="checkbox"/>	<input type="checkbox"/>		
5	Rubella (German measles)	We require evidence of protection. You must attach serology.	<input type="checkbox"/>	<input type="checkbox"/>	Evidence of immunity is required from both male and female clinicians whose work brings them into contact with women of child bearing age.	
6	Are you likely to undertake exposure prone procedures (EPPs) in the work for which you are applying? ⁵		<input type="checkbox"/>	<input type="checkbox"/>	Consider this issue carefully. If "YES", you must answer questions 7, 8 & 9 below	
7	Hepatitis B	You must provide serology which has been taken by and analysed through an NHS department of Occupational Medicine.	<input type="checkbox"/>	<input type="checkbox"/>	We must be able to confirm that the specimen was taken by an NHS Department of Occupational Health. A result from a GP surgery is not acceptable for those undertaking EPPs	
8	HIV	Have you tested positive for HIV?	<input type="checkbox"/>	<input type="checkbox"/>		
9	Hepatitis C ⁶	You must attach evidence of Hep C serology.	<input type="checkbox"/>	<input type="checkbox"/>	Locums and agency staff undertaking EPP must provide evidence.	

HAVE YOU ANSWERED ALL QUESTIONS? IF NOT, YOUR OCCUPATIONAL HEALTH ASSESSMENT CANNOT BE PROCESSED.

³ If yes in what year?

⁴ If yes, in what year, and what was the result. (Please attach documentary proof).

⁵ In order for us to make a proper assessment of the risk of infection, please tell us which countries you have visited, for how long, and whether it was for holiday or work? Continue on page 6 if necessary.

⁶ Exposure prone procedures are those where there is a risk that injury to the health care worker could result in their blood contaminating a patient's open tissues. Exposure prone procedures occur mainly in surgery (including some procedures in minor surgery carried out by GPs), obstetrics and gynaecology, dentistry and midwifery. An illustrative list of exposure prone procedures is contained in *Guidance on the management of HIV/AIDS infected health care workers* and patient notification (issued under cover of Health Service Circular 1998/226).

⁷ Please see the Health Service Circular (HSC) 2002/010 "Hepatitis C infected Health Care Workers"

Your Name: _____

Date of Birth: _____

Please sign and date your **DECLARATION**

1. I understand that giving any materially incorrect or misleading information, or any omission made with the intent of misleading, could lead to the termination of this employment, and if relevant, referral to the appropriate professional body.
2. I acknowledge my professional responsibility to inform the agency if there are any changes to my health which could impact upon my ability to carry out my required job function, or place patients at risk in any way, and I agree to do so.

Signed:		Date:	
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Ensure you have enclosed the following:

All Applicants:

- Completed TB Evidence Form
- Chest X-Ray result (if you have had a CXR in the last 2 years)
- Hepatitis B serology
- Rubella serology
- Evidence of Varicella immune status (if you have not had chickenpox)

Applicants Undertaking EPP:

- Hepatitis C serology

Your Name: _____

Date of Birth: _____



Section and Question	Additional Information you wish to provide

Your Name:

Date of Birth:
