JAK Imaging and Medical Solutions

Tel: 07533326454
Email: admin@jiams.co.uk

APPLICATION FORM

Personal Details

Title: Mr/Mrs/Miss/Ms:	Address:
Surname:	
Forenames:	
Home telephone: Mobile:	
Date of birth:	
Nationality:	
National Insurance Number:	
Email:	
Registered Nurse Pin Number:	
Name and Address of GP: Postcode: Telephone:	
Next of Kin/Emergency Contact: Address: Telephone: Relationship to you:	

Do you have the right to work in the UK? YES NO

Do you hold a current British passport? YES NO

Passport Number:

Do you have a current Driving Licence? YES NO

Do you have access or own a vehicle? YES NO

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Skills and Preferences if applicable to you.

Please indicate which area in which you are skilled and experienced to work			
A/E	Y/N	Chemotherapy	Y/N
Clinics	Y/N	Nursing Homes	Y/N
Gynaecology	Y/N	Domiciliary Care	Y/N
Nurse Practitioner	Y/N	Surgical	Y/N
Medical	Y/N	Residential Homes	Y/N
Neonatal	Y/N	Learning Disability	Y/N
Radiology	Y/N	Radiotherapy	Y/N
Care Homes	Y/N	Care of the elderly	Y/N

Please Indicate the skills you are able to perform independently			
Cannulation	Y/N	Venepuncture	Y/N
IV therapy	Y/N		Y/N
Basic dressings	Y/N	Blood pressure reading	Y/N
Leg Ulcer dressing	Y/N	Tissue viability	Y/N
Syringe driver	Y/N	Catheterisation Male/Female	Y/N
Blood glucose reading	Y/N	Stroke monitoring	Y/N
Intramuscular Injections	Y/N	Subcutaneous injections	Y/N
4 layer bandaging	Y/N	Asthma Care/Monitoring	Y/N
Phlebotomy	Y/N	Blood glucose reading	Y/N

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Employment History

Please give details of ten years of employment history starting from the most recent. Please explain any gaps in employment. Continue on a separate sheet if required

Name of Employer	Address	Position Held	Dates
			From …… To……..
Reason for Leaving			
Name of Employer	Address	Position Held	Dates
			From …… To……..
Reason for Leaving			
Name of Employer	Address	Position Held	Dates
			From …… To……..
Reason for Leaving			

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REFERENCES

Reference 1

Company Name:	
Contact Name:	
Dates of employment:	
Address:	Telephone:
	Email:
	Reason for leaving:

Reference 2;

Company Name:	
Contact Name:	
Dates of employment:	
Address:	Telephone:
	Email:
	Reason for leaving:

Registered Nurses

NMC Number:
LTD Company Number (if applicable):
Company Name and Address:
Unique Tax Reference:

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Criminal Convictions

Subject to filtering rules failure to declare a conviction that you must disclose may require us to exclude you from our register or terminate an assignment if the offence is not declared but later comes to light.

You are legally required to disclose any criminal record under the 'Rehabilitation of Offenders Act 1974'. This includes any convictions whether they are spent or unspent.

NAME:

1. **Do you have any unspent criminal convictions? YES NO**

If yes, please list your criminal convictions and their dates below.

DATE	CONVICTION	OUTCOME

I agree to inform JAK Medical of any pending convictions or prosecutions that may arise whilst registered with the company. I understand that JAK Imaging Medical can request a Criminal Record Bureau Disclosure at any point deemed necessary.

Signature:

Date:

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MEDICAL QUESTIONNAIRE

Full Name:	**Date of Birth:**
Address: **Postcode:**	
Home tel:	**Mobile**
Email:	
Name and Address of GP: **Postcode:**	**Telephone:**

Please answer all the following questions:

Do you have or suffer from any illnesses or disabilities which could affect your work?	YES	NO
Are you receiving or waiting for any medical treatment at the moment?	YES	NO
Do you need any adjustments to enable you to perform your work duties?	YES	NO
Have you lived in the UK for the last 12 months?	YES	NO
If 'no' where did you live before the UK?		
Do you have any symptoms of Tuberculosis?	YES	NO
Is there a family history of Tuberculosis?	YES	NO
Have you had a BCG?	YES	NO
Hve you had Shingles or Chicken Pox?	YES	NO

If you answered 'yes' to any of the above questions, please explain:

Question number	Explanation

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Please confirm you have had the following immunisations:

	YES	NO	Date of immunisation
Poliomyelitis			
Rubella (German Measles)			
MMR			
Hepatitis C			
Hepatitis B			**1st**
			2nd
			3rd
			Booster
Tuberculosis (TB)			
Mantoux Test			
Is your BCG Scar visible?			

I understand that as part of my employment with JAK Medical, I may be asked to undergo a medical health assessment. I understand that my personal details will be handled in accordance with the Data Protection Act 1998.

If I have knowingly withheld or given false medical details I may be subject to disciplinary action.

Signature:

Date:

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Employees Personal Details

SURNAME:
FORENAMES:
MALE OR FEMALE:
DATE OF BIRTH:
HOME ADDRESS: **POSTCODE:**
HOME TELEPHONE:
MOBILE:
EMAIL:
NATIONAL INSURANCE NUMBER:
EMPLOYMENT START DATE:

Employee statement (please tick or cross ONE of the following):

☐ This is my first job since last 6th April and I have not received taxable benefits (Jobseekers Allowance, Employment and Support Allowance, Incapacity Benefit, or Occupational/State Pension).

☐ This is now my only job, but since last 6th April I have had another job or received taxable benefits (Jobseekers Allowance, Employment and Support Allowance, Incapacity Benefit, or Occupational/State Pension).

☐ As well as this, my new job, I have another job or receive a State or Occupational Pension.

I have a student loan that I am NOT paying directly back to the Student Loans Company by agreed monthly instalments: **YES** **NO**

PRINT NAME:

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SIGNATURE:

DATE:

Bank Details

First Name:	**Surname:**
Date of birth:	

Bank/Building Society Name:
Bank/Building Society Address:
Account Holders Full Name:
Account Number:
Sort Code:
Roll Ref Number (Building Society Accounts Only):

Signature:	
Print Name:	**Date:**

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48 HOUR OPT OUT AGREEMENT

NAME:

DEFINITIONS

In this Agreement the following definitions apply:

"Agency Worker" means …….…….. (PRINT NAME);

"Assignment" means the period during which the Agency Worker is supplied to provide services to the Hirer;

"Hirer" means the person, firm or corporate body using the services of the Agency Worker;

"Employment Business" means JAK Imaging and Medical Solutions LIMITED (JAK Medical), Company Registered No. 8916843, Registered office, 34 Windsor Road, Ipswich, Suffolk, IP1 4AN

"Working Week" means an average of 48 hours each week calculated over a 17-week reference period.

References to the singular include the plural and references to the masculine include the feminine and vice versa.

The headings contained in this Agreement are for convenience only and do not affect their interpretation.

RESTRICTION

The Working Time Regulations 1998 provide that the Employee shall not work in excess of the Working Week unless s/he agrees in writing that this limit should not apply.

CONSENT

The Employee hereby agrees that the Working Week limit shall not apply.

WITHDRAWAL OF CONSENT

1.1. The Employee may end this Agreement by giving 30 days' notice in writing.

For the avoidance of doubt, any notice bringing this Agreement to an end shall not be construed as notice of termination of employment by the Employee.

Upon the expiry of the notice period set out in Clause 4.1 the Working Week limit shall apply with immediate effect.

2. THE LAW

This Agreement is governed by the law of England & Wales/Scotland/Northern Ireland and is subject to the exclusive jurisdiction of the Courts of England & Wales/Scotland/Northern Ireland.

_____

Signed by the Employee

Date _____

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Evidential Paperwork

Please bring the following documents with you at interview:

1) Passport.
2) Driving licence.
3) 2x passport photographs.
4) Proof of National Insurance i.e.: NI card, P45, P60, payslip.
5) 2 x proof of address i.e.: utility bill, bank statement.
6) As many training certificates, as possible. To include: Practical Basic Life Support and Manual Handling (see attached list).
7) Proof of inoculations.
8) Proof of bank account.
9) DBS reference number if on yearly update service.
10) **Nurses only:** NMC Statement of entry.
Proof of Indemnity Insurance.
Professional qualification certificate.
If working as Ltd Company:
Ltd Company certificate.
Unique Trading Reference (UTR).
Proof of Ltd company bank account.

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Mandatory Training: check list

Health and Safety	YES/NO
Information Governance/confidentiality.	YES/NO
Fire Safety	YES/NO
Equality & Diversity	YES/NO
Infection Control	YES/NO
Basic food hygiene	YES/NO
Basic Life Support	YES/NO
Moving & Handling	YES/NO
Protection of Vulnerable Adults	YES/NO
Complaints Handling + Conflict Management	YES/NO
Lone Worker	YES/NO

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I confirm that the information I have given in this form are true and accurate. I consent to my personal information and CV being forwarded to clients.

I understand that acceptance unto the JAK medical registered is dependent on satisfactory references, DBS checks and interview /induction.

Print Name:

Sign:

Date: