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EGMS

EMPIRE GLOBAL MEDICAL STAFFING

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info@egms.uk
0117 985 4573
egms.uk

Your Application Pack

NAME	
POSITION (RGN / RMN / HCA)	
RECOMMENDED BY	
REVIEWED BY	
SIGNED BY	

DO YOU HAVE A SUBSTANTIVE CONTRACT WITHIN THE NHS?	☐ YES ☐ NO

Please use BLOCK CAPITALS where possible and return the application pack within 7 days to take advantage of our fast-track application process.

SIGNATURE		DATE	

APPLICANT DETAILS

You will need to provide the following evidence to support your details:

1. Personal Identification
2. Address

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PERSONAL INFORMATION

Title		**Surname**	
Forename			
Middle Name			
Maiden Name			
Marital Status		DATE OF BIRTH	
ADDRESS			
ADDRESS 2		TOWN	
COUNTY		POSTCODE	
LANDLINE PHONE		MOBILE PHONE	
EMAIL			

NEXT OF KIN DETAILS

FULL NAME			
RELATIONSHIP			
ADDRESS			
ADDRESS 2		TOWN	
COUNTY		POSTCODE	
LANDLINE PHONE		MOBILE PHONE	
EMAIL			

TRANSPORT DETAILS

CAR	☐	PUBLIC TRANSPORT	☐
OTHER (Please specify)	☐		

NMC DETAILS

NMC NUMBER		**NMC EXPIRY DATE**	
NMC PART(s) OF REGISTER		NMC PART(s) EXPIRY DATE	
PROFESSIONAL INDEMNITY INSURANCE UNION			

NATIONALITY DETAILS

We do not employ any nurse/carer requiring a work permit or limited leave to remain in the UK.

NATIONALITY			
NATIVE LANGUAGE			
NATIONAL INSURANCE NUMBER			

ELIGIBILITY TO WORK IN UK (*Tick as appropriate*) *Not applicable for UK citizen*	☐ I am eligible to work in the UK and do not require a work permit.
	☐ I am already in possession of a work permit to work in the UK
	☐ I need to obtain a work permit to work in UK
	☐ Other (please specify below)
OTHER	
WORK PERMIT EXPIRY DATE:	

YOUR PAYE / LTD BANK ACCOUNT DETAILS

Your wages are paid directly into your account. Please therefore ensure your details are correct. Incorrect or incomplete details can result in a delay in payment to you.

PAY I wish to be paid through:	
P.A.Y.E (enclose P45) ☐	Ltd Company (private work) ☐
Umbrella ☐	
Umbrella If so, provide details	

Please provide evidence of Your/Ltd/Umbrella (whichever applies) bank account details

BANK DETAILS

PLEASE STATE PAYE OR LTD ACCOUNT			
ACCOUNT HOLDER NAME			
COMPANY NAME (if applicable)			
NAME OF BANK			
ADDRESS			
TOWN		COUNTY	
POSTCODE		SORT CODE	
ACCOUNT NUMBER			

YOUR EMPLOYMENT HISTORY

- Please provide details of your FULL HISTORY in MM/YY format starting from secondary school to date.
- Please explain the gaps in your history. Please continue on a different sheet if required.
- A Comprehensive FULL CV is acceptable provided it lists your full history from secondary school, and details the month and years.

DATE FROM MM/YY	DATE TO MM/YY	EMPLOYER'S NAME AND ADDRESS	POSITION	REASON FOR LEAVING

YOUR PROFESSIONAL CONDUCT

Have there been any proceedings of medical negligence or professional misconduct against?

YES ☐ NO ☐

Have you ever been suspended or dismissed?

YES ☐ NO ☐

If "YES" please supply details:

NAME		SIGNATURE	

REHABILITATION OF OFFENDERS ACT

Due to the nature of the work for which you are applying, Section 4(2), and further orders made by the Secretary of State under the provision of this section of Rehabilitation of Offenders Act (1974) (Exceptions) Order 1975 applies. Applicants are required to give information about convictions which for other purposes are "spent" under the provisions of the Act. Any information given will be confidential and will be considered only in relation for positions to which the order applies.

Have you at any time been convicted of an offence? Yes ☐ No ☐

If yes, give details

YOUR REFERENCE DETAILS

- Please supply the name and work address of at least 2 professional referees.
- One must be from your present or most recent employer and must be a senior grade to yourself.
- 2nd needs to be a previous employer unless you have been employed more than 3 years then it must be someone from your current or most recent employer.

NAME		GRADE		DOB	

1st Reference – Senior Clinical			
NAME			
POSITION			
ADDRESS			
ADDRESS CONTINUED			
TOWN		COUNTY	
POST CODE		EMAIL ADDRESS	
PHONE NUMBER		FAX NUMBER	
DATES FROM		DATES TO	
2nd Reference – Clinical			
NAME			
POSITION			
ADDRESS			
ADDRESS CONTINUED			
TOWN		COUNTY	
POST CODE		EMAIL ADDRESS	
PHONE NUMBER		FAX NUMBER	
DATES FROM		DATES TO	
3rd Reference – Clinical			
NAME			
POSITION			

ADDRESS			
ADDRESS CONTINUED			
TOWN		COUNTY	
POST CODE		EMAIL ADDRESS	
PHONE NUMBER		FAX NUMBER	
DATES FROM		DATES TO	

YOUR CLINICAL EXPERIENCE

Place an "X" in the relevant experience/ years you have in each field, or leave blank if not applicable.

Experiences	0–12 months	1 year +	Experiences	0–12 months	1 year +
A + E – Accident & Emergency	☐	☐	Neonatal	☐	☐
Anaesthetics	☐	☐	Neurology, Rheumatology/Head	☐	☐
Burns	☐	☐	NICU	☐	☐
Cannulation	☐	☐	Nurse Practitioner	☐	☐
Cardiac	☐	☐	Nursing Homes	☐	☐
CCU – Coronary Care Unit	☐	☐	Obstetrics	☐	☐
Chemotherapy	☐	☐	Occupational Health	☐	☐
Child Respite Care	☐	☐	ODP – Operating Department	☐	☐
Clinics	☐	☐	Oncology	☐	☐
Community	☐	☐	Ophthalmology	☐	☐
Dementia	☐	☐	Orthopaedics	☐	☐
Dermatology	☐	☐	Outpatients	☐	☐
Diabetes + BM Testing	☐	☐	Paediatrics	☐	☐
Diagnostic Imaging X-Ray	☐	☐	Palliative Care	☐	☐
Dialysis	☐	☐	PCIU	☐	☐
Diet and Nutrition	☐	☐	Peg Feeding	☐	☐

Domiciliary Care	☐	☐	Physiologists	☐	☐
Drugs and Alcohol	☐	☐	Plastic Surgery	☐	☐
ECG – Electrocardiogram	☐	☐	Prisons	☐	☐
Elderly Care	☐	☐	Radiology	☐	☐
Emergency Admissions Unit	☐	☐	Recovery	☐	☐
Endoscopy	☐	☐	Renal	☐	☐
ENT – Ear, Nose, Throat Ward	☐	☐	Respiratory	☐	☐
General Wards	☐	☐	Rheumatology	☐	☐
Gynaecology	☐	☐	SCABU – Special Care Baby Unit	☐	☐
Haematology	☐	☐	Stroke Unit	☐	☐
HDU – High Dependency Unit	☐	☐	Surgical	☐	☐
Health Visitor	☐	☐	Theatres	☐	☐
ITU – Intensive Care Unit	☐	☐	Tracheostomy Care	☐	☐
IV Drug Administration	☐	☐	Trauma	☐	☐
Learning Disabilities	☐	☐	Triage	☐	☐
Medical Health – Assess/Invest	☐	☐	Urinalysis	☐	☐
Medicine	☐	☐	Urology	☐	☐
Mental Health	☐	☐	Venepuncture	☐	☐
Midwifery	☐	☐	Walk in Centres	☐	☐
MIU – Minor Injuries Unit	☐	☐	Women's Health Unit	☐	☐

YOUR DECLARATION

1.HEALTH

I declare that the answers given within the Declaration of Health form are true and complete to the best of my knowledge and belief. I understand that making false statements or failure to declare health problems could lead to my removal from EGMS.

2.TERMS & CONDITION

I confirm that the information given in this application is, to the best of my knowledge, true. I am permitted to work in the UK. I understand that my registration is subject to the receipt of at least two satisfactory references and enhanced disclosure form the Disclosures and Barring Service. I undertake to inform EGMS should I be convicted of an offence in the future. I undertake to inform EGMS immediately if I am engaged through their induction, including the offer of permanent employment following temporary assignment. I agree to respect the confidentiality of patients and any other information I may have access to, at all times. I have read, retained a copy of, and fully understand the attached "Rules for members working in hospitals. I am clear that EGMS work on a temporary assignment and cannot guarantee any number of hours, they have no responsibility to pay for hours not worked, regardless of the situation. I have read, understood and agree to the terms and conditions of work for temporary agency worker.

3. INDUCTION /INTERVIEW

I have received a copy of the members handbook and can confirm that I am aware that more detailed information on the Policy and Procedure can be obtained directly from EGMS.

4. WORKING TIME REGULATION

For the purpose of the Working Time Regulations, 1998 (as amended), I consent to work in excess of the average of 48 hours per week. I understand that I may withdraw this consent by giving EGMS not less than one week notice. I understand that my registration with EGMS can be terminated at any time, following unsatisfactory work reports.

5. GDPR CONSENT AND DATA PROTECTION

I hereby give my consent to EGMS to process the following information – Personal data (name, date of birth, contact details, telephone numbers, email address, postal address, experience, training, qualifications, CV, national insurance number, gender, nationality, next of kin), Sensitive personal data (disability/health condition relevant to the role, occupational health, criminal conviction).

I consent to EGMS to process the above personal data for the following purposes:

- To provide me with work-finding services, to process or transfer my personal data to their client/s in order to provide me with work-finding services. To process my data on a computerised database in order to provide me with work-finding services. To process my data using automated decision making processes. To process my personal data with third parties including for the purposes of

internal audits, investigations and complaints carried out on EGMS to ensure that the company is complying with all laws and regulations.

6. AGENCY WORKER CONFIDENTIALITY AGREEMENT

I agree that any information given or obtained by me in the course of any placement will be kept in the strictest confidence and in a safe and secure place. I acknowledge no information is to be removed from client premises without the permission of the Client. Any information used will be for the purpose of work and will not be disclosed to third parties or copied except as required in the course of my duties. I agree that any breach of this undertaking by me or any third party to whom I release the information to, may result in legal action proceedings being commenced against me including a claim for the recovery of any losses or damages incurred by the Client as a result of that breach.

7. EGMS HEALTHCARE BULLYING AND HARASSMENT

I am aware that EGMS has a NO Bullying and Harassment policy of which I agree to.

8. 48 HOUR OPT OUT

I agree that I have read and understood the 48 hour Opt Out Agreement of which I have obatined a copy.

9. YOUR WORK HEALTH ASSESSMENT GUIDANCE

The Work Health Assessment requirement as laid down by the Department of Health is that members must complete a health questionnaire to ensure that they are fit to carry out the duties required. For new starter members of EGMS you are required to conduct an Occupational health pre-employment screening prior to your first placement. This must be updated on an annual basis.

10. EGMS HANDBOOK DECLARATION (JAN 2022)

I agree I have received a copy of the latest EGMS Medical handbook, which outlines the goals, policies, procedures and expectations of EGMS, its clients and my responsibilities as an employee.

11. EQUAL OPPORTUNITIES – Equality Act 2010

EGMS have a clear objective and policy to embrace all of the principles of equality and opportunity. All staff are expected to operate within the framework of this policy. As part of the monitoring process, we encourage all joining members to complete the Equal Opportunities Form.

SIGNED:		DATE:	

YOUR WORK ASSESSMENT HEALTH GUIDANCE

The Work Health Assessment requirement as laid down by Department of Health is that members must complete a health questionnaire to ensure that they are fit to carry out the duties required. For new starter members EGMS is required to conduct Occupational health pre-employment screening prior to your first placement. This must also be updated on an annual basis.

Please read the following and state if applicable:

1. I am not aware of any health conditions or disability which may impair my ability to undertake effectively the duties of the position which I have been offered.

Yes ☐ No ☐

2. I do have a health condition or disability which might affect my work and which might require special adjustments to my work or at my place of work

Yes ☐ No ☐

If you have answered "YES" please provide details below			
NAME		SIGNATURE	

CONFIDENTIALITY
Information contained within this document is governed by the Data Protection Act 1998. Disclosure of information is only with your informed written consent. Recommendations to your employer will be directed to essential information regarding your health, hazards & risks of your employment, and with due reference to other relevant statutory requirements and professional practice.

OCCUPATIONAL HEALTH SERVICE
Although we can verify a BCG scar via our onsite Nurse, we do not carry out any blood tests or vaccinations. Please contact your local Occupational Health department or GP if you require this service.

AVAILABILITY QUESTIONNAIRE

1. Where did you hear about us?	
☐ Internet Search	☐ Job Centre
☐ Social Media	☐ Leaflet
☐ Recommendation	☐ Other (please specify)
2. Would this be your main job or secondary income?	
☐ Main Job	☐ Secondary Income
3. Approximately how many shifts would you like to work per week? 1–2 ☐ 2–4 ☐ 4+ ☐	
4. What is your preferred shift pattern? Early ☐ Late ☐ Night ☐ Long Day ☐ No Preference ☐	
5. Please detail dates of any time off or planned holiday	

6. Please choose your preferences for establishments

	Hospitals	Community	Nursing Homes	Prisons
South	☐	☐	☐	☐
South East	☐	☐	☐	☐
South West	☐	☐	☐	☐
Midlands	☐	☐	☐	☐
North	☐	☐	☐	☐
Other/ specific locations				

NEW APPLICANT INTERVIEW

Applicant Name: _____

Date: _____/_____/_____

Location: EGMS Office ☐ Online ☐ Telephone ☐

What experience do you have in the Healthcare Sector?	
What are you mainly looking to get out of joining our Agency?	
What qualities do you feel you have to make this role a success?	
What do you enjoy most about the Healthcare industry?	
Do you consider yourself to be social? If so, give an example of where your social skills helped the patient.	
Have you been involved in an emergency situation on your own? What did you do?	
Can you explain the term "Whistleblowing"? and problems associated with it?	
How would you deal with a difficult patient?	

Can you explain the term "Confidentiality", and how do you maintain it?	
Can you explain the term "UTI" and what is the primary cause of this?	
Can you explain the term "Vulnerable" and what would you do if someone was being exploited?	
Interviewer Name	
Interviewer Position	
Interviewer Signature	

Trained Nurses Responsibilities

All Trained Nurses MUST;

- Keep up to date with nursing practice according to the NMC Guidelines.
- Administer all medications in line with the NMC Guidelines for the Administration of Medicines at all times.
- Abide by the EGMS code of conduct and the Employer's code of conduct at all times while on duty.
- Comply with all Rules and regulations of the Employer at all times while on duty.

All cancellations will be recorded regardless of grade. All members are required to work within the Companies Policies. A copy is available in the Office. Please feel free to ring in with any problems you may have as we are here to offer you support.

Name	
Signature	
Date	