Freepost RRTA-AKKK-ZGUU
dr-locums
7 Houghton Square
London SW9 9AN
t 020 7498 7999
f 020 7498 2221
e nurse@drlocums.com
w www.drlocums.com

NURSING LOCUM APPLICATION FORM

PERSONAL INFORMATION

Title:	Sex: ❑ Male ❑ Female	Address:
Surname:	Tel:	
Forename (s):	Mobile:	
Position Applied For:	Driving Licence: ❑ Yes ❑ No	
DOB:	Email:	
Marital Status:	Nationality:	
NI Number:	Tax Office Ref:	Postcode:
Are You Prepared to Accept an Early Morning Call/or Calls Late at Night: ❑ Yes ❑ No		Car Owner: ❑ Yes ❑ No
How Far Are You Willing to Travel?		

NEXT OF KIN/EMERGENCY CONTACT DETAILS

Name:	Address:
Relationship:	
Mobile:	
Landline:	Postcode:

PROFESSIONAL DETAILS

NMC Number:	Date of Registration:	Expires:
Registration Categories:		

PRIMARY QUALIFICATIONS: (RGN, RMN, RNLD, RNSL, RHV, EN, RFN, RM, RSCN, RH, ENM, ENG, ENMH, RNMH)

Qualifying Degree:	Date of Award:
Institution:	

OTHER QUALIFICATIONS

Name:	Date of Award:
Institution:	
Name:	Date of Award:
Institution:	
Name:	Date of Award:
Institution:	
Others: (If necessary, please list use on a separate sheet)	

BLS OR HIGHER CERTIFICATION (ALS, ATLS, PALS etc)

Name:	Date of Award:
Institution:	

PROFESSIONAL MEMBERSHIPS (RCN, UNISON etc)

Name:	Expiry:
Name:	Expiry:

APPRAISAL

Date of last Appraisal:	Appraiser:

PRACTICE RESTRICTIONS (if applicable, please provide details on a separate sheet)

Have you ever been the subject of a professional conduct/competence enquiry?	❑ Yes	❑ No
Are you aware of any professional conduct/competence enquiries being considered against you?	❑ Yes	❑ No

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REFERENCES

Referee1		
Name:		
Relationship:		
Address:		
	Postcode:	
Telephone:	Fax:	Email:

Referee2		
Name:		
Relationship:		
Address:		
	Postcode	
Telephone:	Fax:	Email:

Referee3		
Name:		
Relationship:		
Address:		
	Postcode	
Telephone:	Fax:	Email:

RIGHT TO WORK IN THE UK (NOT APPLICABLE TO EU NATIONALS)			
Immigration Status:			
Passport Number:		Expiry:	
Visa Number:		Expiry:	
Special Conditions:			
Copy of visa	❑ Enclosed	❑ To follow	We cannot offer you sessions without this.

CONVICTIONS		
Have you ever been convicted of a criminal offence? (nursing is exempt from the Rehabilitation of Offenders Act 1974 and as a result you must declare spent convictions)	❑ Yes Please provide details	❑ No
Are you aware of any circumstances that may lead to you being convicted of a crime?	❑ Yes Please provide details	❑ No
We shall rely on the information when screening your application. To knowingly make a false statement above could be a criminal offence. By signing below you confirm that the information that you have provided above is complete and true. You also confirm that you consent to us checking details provided in support of this application against various data sources in order to verify your identity & process this application.		
Signed:	Date:	NMC PIN:

YOUR CURRENT CRB		
Have you had a CRB Enhanced Disclosure conducted within the last 2 years?	❑ Yes	❑ No
If no, date of last CRB:		
If your current CRB Enhanced Disclosure is more than 12 months old we can organise a free CRB check for you.		

SECURITY CLEARANCE (MoD, Prison etc)			
Do You hold any form of current Security Clearance?		❑ Yes	❑ No
Date Granted: / /		Level of Clearance:	
Expiry Date: / /		Place of Work when granted:	

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WHICH GP MEDICAL INFORMATION SYSTEMS CAN YOU USE? PLEASE GIVE PROFICIENCY SCORES OUT OF 5 (MAXIMUM)							
Emis LV:	❑ Yes	❑ No	Proficiency:	**iSOFT(Torex Synergie)**	❑ Yes	❑ No	Proficiency:
Emis PCS:	❑ Yes	❑ No	Proficiency:	**iSOFT(Torex Premier)**	❑ Yes	❑ No	Proficiency:
Vision	❑ Yes	❑ No	Proficiency:	**SystmOne TPP**	❑ Yes	❑ No	Proficiency:
Adastra:	❑ Yes	❑ No	Proficiency:	**OTHER**	❑ Yes	❑ No	Proficiency:

LANGUAGES		
In addition to English, do you speak any other languages	❑ Yes	❑ No
If yes, please let us know which ones and your proficiency (1=Basic, 5=Native)		

LANGUAGE	PROFICIENCY	LANGUAGE	PROFICIENCY

YOUR PROFESSIONAL SKILLS

Skill Matrix (Please circle as appropriate)

1. No understanding or knowledge.
2. I Understand the procedure, but have not performed it.
3. I have seen this procedure and would need supervision.
4. I am used to this skill and can perform independently.

PREVENTIVE CARE					COMMENT
Travel Health including immunization, malarial prophylaxis & preventative health advice	**1**	**2**	**3**	**4**	
Smoking cessation advice (state level)	1	2	3	4	
Routine immunization for national program	1	2	3	4	
NHS Health Checks	1	2	3	4	
Experience of proactively identifying, diagnosing and managing treatment plans for patients at risk of developing a long – term condition	1	2	3	4	
Support patients to adopt health promotion strategies that promote health lifestyles and apply principles of self – care support	1	2	3	4	
ROUTINE HEALTH CARE					
Phlebotomy	1	2	3	4	
Tissue Viability	1	2	3	4	
WOMEN'S HEALTH					
Women's Health checks including cervical cytology	1	2	3	4	
Comprehensive contraceptive advice & treatment	1	2	3	4	
Oral contraceptive checks	1	2	3	4	
Injectable contraceptive checks	1	2	3	4	
Pre-conceptual care & advice	1	2	3	4	
Pregnancy Testing	1	2	3	4	
LONG TERM CONDITIONS					
Asthma Care	1	2	3	4	
COPD Care	1	2	3	4	
B12 therapy monitoring	1	2	3	4	
Diabetes care					
Insulin starts and/or titration	**1**	**2**	**3**	**4**	
CVD Care	1	2	3	4	
Heart Failure Care	1	2	3	4	

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Epilepsy Care	1	2	3	4	
Experience of caring for those with support needs	1	2	3	4	
Work with patients in order to support compliance with and adherence to prescribed treatments Provide information and advice on prescribed or over-the-counter	1	2	3	4	
Prescribe and review medication for therapeutic effectiveness, appropriate to patient needs and in accordance with evidence-based practice and national and practice protocols, and within scope of practice	1	2	3	4	
MINOR ILLNESSES					
Physical Assessment Training	1	2	3	4	
Experience of providing expert clinical leadership in the care of minor injuries/illness	1	2	3	4	
Clinically examine and assess patient needs from a physiological and psychological perspective, and plan clinical care accordingly	1	2	3	4	
Diagnose and manage both acute and chronic conditions, integrating both drug- and non-drug-based treatment methods into a management plan	1	2	3	4	
Prioritize health problems and intervene appropriately to assist the patient in complex, urgent or emergency situations, including initiation of effective emergency care	1	2	3	4	
Undertake minor surgery as appropriate to competence	1	2	3	4	
Use a structured framework (eg root-cause analysis) to manage, review and identify learning from patient complaints, clinical incidents and near-miss events	1	2	3	4	
URGENT CARE					
Triage	1	2	3	4	
Assess and manage minor illness autonomously	1	2	3	4	
Order investigations and referral management	1	2	3	4	
PRESCRIBING	1	2	3	4	
Do you have the license to prescribe independently?	❑ Yes		❑ No		

LIMITED COMPANY DETAILS – All locums are required to work through a Limited Company, we do not offer a PAYE service. Your umbrella company will send the necessary documents automatically. If you are not registered with one, we can send you a list of providers that we work with. **If you would like to use your own company, we cannot register you under it without these documents.**

Name of Limited Company:
Company Incorporation Certificate:
Certificate of Employers Liability Insurance:
Professional Indemnity Certificate:

BANKING DETAILS

Bank Name:	
Bank Address:	
	Postcode:
Account Name:	
Account Number:	Sort Code:

INTERVIEW

In keeping with current best practice & NHS Employer guidelines, we are required to interview you in person, verify your identity and take photographs for your ID badge. You can either pop into the office to have this done any time between 09:00 and 18:00, Monday to Friday. If you cannot come down to the office, it may be possible for a member of our team to meet with you. If you prefer this option, please get in touch with our team to arrange something convenient. Please call our nursing team on 020 7498 7999.

At Interview, we will need to see originals of all your documents. Please ensure that you bring these with you.

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DECLERATION

By signing below, you confirm that the information that you have provided above is complete and true and that you have reviewed our terms of engagement (available on our website) and accept them in full. You also confirm that you consent to us checking the details provided in support of this application against the various data sources in order to verify your identity and process this application. These details may be recorded and where appropriate shared with other organisations for purposes such as review, compliance, audit, complaint management, best practice development etc. If you would like to know more, please contact a member of our team. We shall rely on this information when screening your application. To make a false statement as a part of this application could be a criminal offence.

Signature:	**Date:**
Name:	**NMC PIN:**

WORKING TIME REGULATIONS

The Working Time Regulations 1998 require us to limit your average weekly working time to 48 hours unless you agree that the limit shall not apply to you (i.e. you opt out). You are under no obligation to do this and can rescind your agreement to opt out by giving us with 7 days notice.

❑ **Yes I agree to opt out , please do not limit the hours I work**

❑ **No I do not agree to opt out, please limit my working week**

Signature:	Date:

FINAL CHECKLIST

Please supply a copy of the following:

❑	Up to date CV (With all gaps in employment explained)	❑	2x Photo ID
❑	NMC Pin Card and Statement of Entry	❑	2 x Proof of Address (Within six months)
❑	BLS Certificate	❑	Existing CRB Disclosure (Issued within 12 Months)
❑	Proof of Training for any clinics, procedures etc	❑	Passport Photograph
❑	Proof of Hep B vaccination (SAg for EPPs)	❑	Occ Health Questionnaire (attached)
❑	Proofs of immunisations or Occ Health printout	❑	Mandatory training certificates (CPT, Infection Control etc)
❑		❑	

Please send your form in to:

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Feel free to pop down and meet us: We make bad coffee and great conversation! Call us on 020 7498 7999 to arrange a visit. We look forward to meeting you ☺

REFERRAL

Earn up to £500 for referrals per Nursing Locum introduced!

It's simple, refer your friends & colleagues to locum for us & earn £1/hour for work they do (max of £500 per Nursing Locum intro)

Name:	Contact No:	Email:
Name:	Contact No:	Email:
Name:	Contact No:	Email:

HOW DID YOU HEAR OF dr-locums?

Friend:	❑	Name of Friend:	
Internet:	❑	Direct Marketing (Mail Shots, Email):	

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OCCUPATIONAL HEALTH QUESTIONNAIRE

GP DETAILS		
Name:	**Tel:**	**Fax:**
Address:		

BASIC HEALTH HISTORY	Yes	No	Details If Yes
Working in conjunction with the RCN and NHS employers guidelines there any aspect of your health that may affect your ability to work as a locum?	❑	❑	
Are you under the care of medical profession?	❑	❑	
Have you knowingly been in contact with MRSA? If yes, were you swabbed and what were your results and dates?	❑	❑	
Are you currently taking any medications? (If yes, please only provide us with details of the condition and the degree to which managed.)	❑	❑	
Do you have any impairments of vision, hearing or mobility?	❑	❑	
Have you ever suffered from any mental illness (including depression) or had a nervous breakdown?	❑	❑	
Are you attending hospital for any treatments or are you on the waiting list for any treatment(s)?	❑	❑	
Have you any reason to believe you may be infected by any communicable disease?	❑	❑	
Do you suffer from blackouts, fits or attacks of giddiness?	❑	❑	
Do you suffer from chest pains, heart condition or raised BP?	❑	❑	
Do you suffer from asthma, bronchitis or other chest complaints?	❑	❑	

IMMUNISATIONS/ INFECTIONS	Yes	No	Details If Yes
Rubella (German Measles)	❑	❑	
Varicella (Chicken Pox)	❑	❑	
MMR (Mumps, Measles, Rubella)	❑	❑	
Diphtheria	❑	❑	
Poliomyelitis	❑	❑	
Tetanus	❑	❑	
Have you had at least 2 Tetanus boosters since age 12?	❑	❑	
Tuberculosis (BCG)	❑	❑	
Do you have a visible BCG scar of at least 4mm diameter?	❑	❑	

HEPATITIS B	Yes	No	Details If Yes
Date of primary course of vaccine:	❑	❑	
Dates of subsequent boosters:	❑	❑	
Date of most recent Titre Check:	❑	❑	
Titre level at check:	❑	❑	

ILLNESSES	Yes	No	Details If Yes
Have you ever had?	❑	❑	
Measles	❑	❑	
Rubella (German Measles)	❑	❑	
Varicella (Chicken Pox)	❑	❑	

Signed:	**Date**
Name:	**NMC No:**