Ambar Care Ltd
799 London Road
West Thurrock
Grays
Essex, RM20 3LH
Tel: **01708608586**
Email: info@ambarcare.co.uk
Website: http://www.ambarcare.co.uk

Dear Applicant

As part of your registration with Ambar Care Ltd, you are required to bring the following documents when you attend your interview.

Valid Passport with proof of eligibility to work in the UK. If in college or university a letter of acceptance.

Proof of National Insurance (NI card/payslip/P45/P60)

Marriage Certificate/Birth Certificate/Driver's Licence

Proof of Address (utility bill/bank statement/credit card statement) must be within the last 3 months.

Annual Mandatory Training Certificates i.e. (CPR) Basic Life Support, Moving and Handling, Fire Safety, Infection Control, paediatric life support, Health and Safety

Proof of Qualification (Degree/Diploma/NVQ etc.)

NMC Pin and Statement of Entry (for registered nurses only)

Updated CV

Two Passport Sized Photographs

Proof of Union Membership

IMMUNIZATION Details: Rubella, Varicella, TB (scar verification by GP or occupational health, measles/mumps, Hep B (surface antibody including titre level). Also, hep C, HIV 1+2, Hep B surface (if Exposure Prone Procedure nurse/OPD/midwife)

DBS Fee £ 60.00

Skills & Drills, RCM for Midwives

CPR New Born (midwifery only)

Control and Restraint Certificate (RMN only)

Please bring the following original documents on the day of your interview.

Note: Items 1 - 3 are mandatory

1. Passport
2. Valid Visa or Work Permit (where applicable)
3. Valid Pin Number
4. 2 Passport sized photographs
5. Training Certificates and CV
6. DBS Details
7. Completed Application Form
8. Other Qualification
9. Names and Addresses of 2 referees
10. Criminal Conviction Declaration
11. Health Declaration
12. National Insurance Number
13. Bank Details (required in order for us to pay you)
14. Bank Statement/Utility Bill

Personal Details	
First Name:	Email Address:
Middle Name:	Home Phone Number:
Surname:	Mobile Phone Number:
DOB:	NI Number:
Current Address:	
Next of Kin:	Relationship:
Telephone Number:	Mobile Number:
Current Address:	
Do you have the right to work in the UK? **Yes / No**	
What is your right to work in the UK?	☐ EU Citizen
	☐ Indefinite Leave to Remain
	☐ Limited Leave to Remain
	☐ Other, please specify

Professional Registration

Please tick as appropriate

☐ HCPC (formerly HPC)	☐ NMC	☐ GMC	☐ GPHC	☐ RCCP	☐ Other

Professional Indemnity Insurance

Insurance Provider:	
Insurance Policy Number:	Expiry Date:

Qualifications

Please begin with the most recent qualification

Institution: Uni/College/Other	Full Address of Institution	Date from/to:	Qualification:

Please continue on separate page if necessary and attach CV.

Employment History

- We need details of all your employment, commencing with your most recent job.
- Where applicable, please explain any breaks in employment history.

Dates From	To	Name & Address of Company	Position Held	Duties Performed

Disclosure and Barring Service Checks

Please note you will be subject to an Enhanced DBS Check. Because you are a health care worker you are not exempt from the Rehabilitation of Offenders Act 2010. This means that all convictions, cautions, reprimands and final warnings on your criminal record **must** be disclosed prior to working with us.

Have you ever been convicted by the courts, cautioned, reprimanded or given a warning by the police in the UK or any other country?	Yes ☐	☐ No
Are you aware of any police enquiries undertaken following allegations made against you, which may affect your suitability for this role?	Yes ☐	☐ No
Are you aware of any pending investigations by the police in which you are Involved?	Yes ☐	☐ No

If you have answered yes to any of the above questions, please provide **full** details of the incident below:

Professional References		
Reference from your current or most recent post		
Organisation:		Ward/Department:
Name (Referee) :		Professional Title:
Dates Employed:	From:	To:
Work Address:		Work Email:
		Telephone:

Second Reference		
Organisation:		Ward/Department:
Name (Referee) :		Professional Title:
Dates Employed:	From:	To:
Work Address:		Work Email:
		Telephone:

Clinical Details for Nurses/Midwives/Support Workers and HCA's

Clinical Area	Length of Experience	Clinical Area	Length of Experience
A&E		Neurology	
Ante Natal		Nursing Homes	
Cardiac		Occupational Health	
Care of the older person		OPD	
Community Nursing		Oncology	
Cosmetic Surgery		Orthopaedics	
Day Care Unit		Paediatrics	
District Nursing		Practice Nurse	
Family Planning		Prisons	
G U Medicine		Radiology	
Gynaecology		Recovery	
Haematology		Renal	
Health Visiting		Residential Homes	
High Dependency Unit		SCBU	
Home Care		School Nurse	
Hospices		Scrub Nurse	
Hospitals		Surgical	
Intensive Care Unit		Theatres	
Learning Disability		Urology	
Medical Assessment Unit		Other	
Mental Health			

Midwifery			
Neonatal/ PICU			

HCA/Support Worker Skills Drill

Urinalysis	☐	Simple Dressings	☐
Catheter Care	☐	Blood Sugar Testing	☐
Continence Care	☐	Stoma Care	☐
TPR Recording	☐	Pressure Area Care	☐
B/P Recording	☐	Mouth Care	☐
Use of Hoists	☐	Eye Care	☐
Report Writing	☐	Feeding patients	☐

New Employee Heath Questionnaire

Strictly Confidential

All applicants are required to complete this Health Questionnaire. Any positive answers will not necessarily affect your application. Please list any medical conditions which may affect your ability to do the job or place you at risk in the work place, give as much details as possible. Further details can be given on a separate sheet.

Personal Details

First Name:	Surname:	DOB:
Home Phone Number:	Mobile Phone Number:	
Current Address:	GP Address:	

Medical History

This is mandatory	Yes	No
Do you have any illness/impairment/disability (physical or psychological) which may affect your work?	☐	☐
Have you ever had any illness/impairment/disability which may have been caused or made worse by your work	☐	☐
Are you having, or waiting for treatment (including medication) or investigations at present? If your answer is yes, please provide further details of the condition, treatment and dates	☐	☐
Do you think you may need any adjustments or assistance to help you to do the job	☐	☐

Further Details (If you have answered yes to any of the questions above please provide additional information below)

Tuberculosis

Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006)	**Yes**	**No**
Have you lived continuously in the UK for the last 5 years	☐	☐
If you answered no above, please list all of the countries that you have lived in over the last 5 years		
Have you had a BCG vaccination in relation to Tuberculosis?	☐	☐
If you answered yes, please state when	Date:	
Do you have any of the following?		
A cough which has lasted for more than 3 weeks	☐	☐
Unexplained weight loss	☐	☐
Unexplained fever	☐	☐
Have you had tuberculosis (TB) or been in recent contact with open TB	☐	☐
Additional Information If you have answered yes to any of the questions above, provide additional information:		

Chicken Pox and Shingles			
Have you ever had chicken pox or shingles?	Yes ☐	No ☐	Date:
Immunisation History			
Have you ever had any of the following immunisations?	Yes	No	Date:
Triple vaccination as a child (Diphtheria / Tetanus / Whooping cough) ?	☐	☐	
Polio	☐	☐	
Tetanus	☐	☐	
Hepatitis B (If Yes is ticked please give dates below)	☐	☐	

Course	1:	2:	3:
Boosters	1:	2:	3:

Immunisation History and Proof of Immunity					
Condition	**Yes**	**No**	**Date of Test**	**Test Results**	**Proof of Immunity**
Mumps, Measles and Rubella MMR					Certificate showing two MMR results or blood test result showing Immunity levels.
Varicella					Immunisations certificate or blood test result showing immunity levels.
Hepatitis B					Recent pathology report showing titre levels of 100lu/l or above
Hepatitis B Surface Antigen					Proof of negative result
Tuberculosis					GP/Occupational Health certificate of a positive scar or record of positive skin test
Poliomyelitis					
Tetanus					

Additional Proof of Immunity for Candidates whose Duties will involve Exposure Prone Procedures			
Condition	**Date of Test**	**Results**	**Proof of Immunity**
Hepatitis C			Proof of Negative Results
HIV			Proof of A negative antibody test

Availability for Work

How many hours would you like to work each work?				Hours:			
Which areas would you be able to work in?				Please List			
	Mon	**Tues**	**Weds**	**Thurs**	**Friday**	**Sat**	**Sun**
Early Shift							
Late Shift							
Long Day							
Night Shift							
Do you drive?	Yes			No			
If you intend to use your car for work, do you have the required insurance cover?				Yes		No	
If yes please produce your driving license and motor insurance certificate on the date of interview.							

Do you have any other work commitments which may impair your ability to carry out your duties for Ambar Care?	Yes (Please give details)	No

Bank/Building Society Details

Name (Account Holder):	Bank Name:
Account Number:	Sort Code:

I authorise Ambar Care to pay my weekly earnings directly into my account or building society using the details I have given above. I confirm that I will notify Ambar Care of any changes to these details.

Signature:…….. Date:……

Equal Opportunities Monitoring

Nationality				
Age Group (Please indicate)	16-20	21 - 35	36 - 50	50+
Disabilities (Please indicate)	Registered disability	Unregistered disability		No disability
Ethnicity (please indicate which best describes your ethnic origin)	African	European	White other	
	Black Caribbean	Black other	Indian	
	Pakistani	Chinese	Other (Please specify)	
How did you hear about the post?				
Are you related to or do you know any member of staff at Ambar Care?				

Declarations

Please read the following declaration carefully. Make sure that you sign and date all declarations.

Working Time Directive

Regulations 4 of the Working Time Directive requires that a worker's average time spent at work does not exceed 48 hours within 1 rolling week unless the worker hereby agrees to exceed this limit.

I hereby confirm that I am willing to opt out of the Working Time Directive. I understand that I can opt out of this agreement at any time provide Ambar Care Ltd with one week's notice.

Signed:	Dated:

Please note should you choose to not opt out of the Working Time Directive that it is your responsibility to ensure that you do not work in excess of 48 hours per week.

1. I declare that the information provided by me to Ambar Care Ltd is true and accurate and has not been presented in a way to mislead or misinform. I agree that if I have given false or misleading information, if I have omitted or subsequently omit, information which may affect my ability to work in my chosen profession that Ambar Care Ltd may cease to offer me further placements with immediate effect.

2. I am not aware of any condition, medical or otherwise. which would affect or limit my performance or employment other than those provided, including information provided in Occupational Health Questionnaire.

3. I hereby give permission for Ambar Care Ltd and its subsidiaries to apply for and Enhanced DBS Check and I declare that I have not withheld any information which may be later disclosed by the DBS.

4. I hereby give permission for Ambar Care Ltd to obtain all my occupational health results and reports, qualifications and training information where necessary.

5. I herby give permission for Ambar Care Ltd to contact the UKBA to perform a check on my Biometric Residence Permit.

6. I acknowledge that my personal details will be stored and used by Ambar Care Ltd in strict accordance with the Data Protection Act 1998. I agree that all information provided to Ambar Care Ltd can be made for audit/review by relevant third parties.

7. I hereby agree to immediately notify Ambar Care Ltd of any changes to to my circumstances or personal information including but not restricted to changes in my health charges or investigations at work at work changes to my DBS record or suspensions by my regulatory body.

8. I hereby agree that I will act in a professional manner at all times when representing Ambar Care Ltd and that I will fully co-operate with the instructions duties allocated to me during each and every placement.

9. I will immediately inform Ambar Care Ltd if any complaint is made against me whilst on assignment for Ambar Care Ltd

10. I acknowledge that it is my responsibility to ensure that my skills and continuously update and that I will always endeavour to carry out my duties and responsibilities to the best of my ability.

11. I can confirm that I have been given a copy if the Terms and Conditions of Service issues by Ambar Care Ltd that I have read those Terms and agree to abide by them at all times.

12. I agree to abide by the Protection Act 1998 with regard to all information about Ambar Care Ltd clients, candidates, patients and any other third party who I interact with during my registration with Ambar Care Ltd. I will not attempt to deliberately procure any information pertaining to Ambar Care Ltd clients, candidates, patients and any other third parties that would be outside of my job description. I will not discuss information either verbally or in writing and if I am not unsure about how to treat any information I shall immediately contact Ambar Care Ltd Senior Management clarification.

13. I can confirm that I have received the Ambar Care Ltd hand book and that I will abide by the code of conduct thereby set out. This code incorporates the code of conduct as set out by regulatory bodies the NMC, GMC and HCPC. I therefore agree that I will:

- Respect the patient of client as an individual
- Obtain consent before I give any treatment or care
- Protect confidential information
- Co-operate with others in my team
- Maintain my professional knowledge and competence
- Be trustworthy
- Act to identify risk to patients and clients
- Abide by the rules and regulations of the departments in which I work

Signed:	Dated:

Declaration of Truth

I, the undersigned applicant, hereby confirm the truth of the contents of this application.

Signed: ……. Date: …….

Health Declaration:

I certify that the information given in the above Health Questionnaire is accurate and true to the best of my knowledge, and I understand that this information will be held, in confidence by Ambar Care Ltd.

Signature: ……. Date: ……

Induction Declaration:

This is to declare that I have received and understood the Ambar Care Staff Handbook, the Ambar Care Code of Practice, Ambar Care Policies and Procedures. I have attended and understood the Ambar Care Ltd Induction Training.

Signature: ……. Date: ……

Confidentiality Agreement:

During the course of your employment you may have access to see or hear information of a confidential nature. You are required not to disclose any information, particularly relating to client/patient details, medical notes etc, to any unauthorised persons. You are reminded that any breach of confidentiality may result in disciplinary action or dismissal.

Signature: ……. Date: ……..