



Head Office & Accounts: P.O. Box No. 165
BARNSTAPLE
Devon. EX32 8YJ.

REGISTERED by the CQC:
www.ecna.co.uk
Email: enquiries@ecna.co.

APPLICATION FOR REGISTRATION FOR QUALIFIED NURSES.

Please use capital letters and complete all sections. If you have any difficulty completing this form ask someone to help you. It may be completed at an interview if you prefer.

In accordance with the Data Protection Act (1984) you are advised that you have the right of access to information from this application form, which may be held on computer database. ECNA aims to satisfy the needs of clients by providing equal opportunities for applicants and members irrespective of their sex, age, marital status, racial or ethnic origin, physical disability or sexual orientation.

CONTACT DETAILS:			ECNA REF. NUMBER:										
TITLE:		SURNAME:											
FORENAMES:													
HOME TELEPHONE:													
MOBILE:					Email:								
CURRENT ADDRESS:													
PLEASE PROVIDE THE FULL ADDRESSES OF WHERE YOU HAVE LIVED OVER THE PAST 5 YEARS:													
FROM:	TO:	ADDRESS (INCLUDE POST CODE):											
PERSONAL DETAILS:													
PREVIOUS NAMES (IF ANY)													
BIRTHPLACE:													
NATIONALITY:													
ETHNIC ORIGIN:		BLACK/WHITE/AFRO CARIBBEAN/OTHER											
NATIONAL INSURANCE NUMBER:													
PASSPORT NUMBER:							DATE OF ISSUE:						
EXPIRY DATE:													
DO YOU NEED A VISA TO WORK IN THE UK? YES / NO													
NEXT OF KIN NAME:								RELATIONSHIP:					
TELEPHONE:				HOME:				OTHER:					
NMC REGISTRATION:													
NMC REGISTRATION NUMBER (PIN):													
RECORDED PARTS ON NMC REGISTER:													
EXPIRES LAST DAY OF:				MONTH:				YEAR:					
DATE OF REGISTRATION:				MONTH:				YEAR:					

PROFESSIONAL DETAILS:**NURSING QUALIFICATIONS:****SPECIALISATIONS:****TRAINING:**

TRAINING COURSES ATTENDED:	YES	NO	DATE	LOCATION of COURSE:
MOVING & HANDLING				
FIRST AID				
FIRE SAFETY				
COSHH				
RIDDOR				
HEALTH & SAFETY				
BASIC LIFE SUPPORT				
INFECTION CONTROL				
MIDWIVES ONLY-RESUSCITATION OF NEWBORN AND INTERPRETATION OF CARDIOTOCOGRAPH TRACES				

NURSE TRAINING ESTABLISHMENTS:

ADDRESS:	DATE FROM:	FINISH DATE:

EMPLOYMENT:

Previous employer (s) and address(s) Please include any voluntary work. THIS MUST COVER THE LAST 10 YEARS	Position (s) held	Did it involve work with children / vulnerable adults? YES/NO	From: Month / Year	To: Month / Year	Reason for leaving

CONTINUE ON A SEPARATE SHEET IF NECESSARY.

PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS IN YOUR EMPLOYMENT HISTORY:

CONTINUE ON A SEPARATE SHEET IF NECESSARY.

CONVICTIONS:					
NOTE: UNDER THE REHABILITATION OF OFFENDERS ACT 1994, QUALIFIED NURSES AND THOSE PROVIDING HEALTH CARE MAY NOT CLAIM SPENT OFFENCES. YOU ARE THEREFORE REQUIRED TO DISCLOSE ALL CRIMINAL CONVICTIONS.					
DO YOU HAVE ANY CONVICTIONS FOR CRIMINAL OFFENCES?				YES	NO
IF YOU HAVE ANSWERED 'YES' TO THE ABOVE QUESTION, PLEASE GIVE DETAILS BELOW:					
DATE OF CONVICTION/JUDGEMENT:					
DAY:	MONTH:	YEAR:	DETAILS OF OFFENCE:	COURT NAME & ADDRESS:	
CONTINUE ON A SEPARATE SHEET IF NECESSARY.					

CHARACTER REFERENCES:			
PLEASE PROVIDE THE DETAILS OF TWO QUALIFIED PEOPLE WITH WHO YOU HAVE WORKED, WHO WILL PROVIDE A CHARACTER REFERENCES. RELATIVES ARE EXCLUDED.			
1)TITLE:	SURNAME:	FORENAME:	ADDRESS:
MEDICAL QUALIFICATION:		HOME TELEPHONE No.	FAX NUMBER:

2)TITLE:	SURNAME:	FORENAME:	ADDRESS:
MEDICAL QUALIFICATION:		HOME TELEPHONE No.	FAX NUMBER:

EMPLOYMENT REFERENCES:		
PLEASE PROVIDE DETAILS OF THE LAST 2 PLACES YOU HAVE WORKED FOR:		
1) ORGANISATION NAME & ADDRESS:		
POSITION HELD:	TEL NO:	FAX NO:
2) ORGANISATION NAME & ADDRESS:		
POSITION HELD:	TEL NO:	FAX NO:

DECLARATION OF HEALTH

If the answer is yes to any of the questions in this section, please give full details in the space provided of the dates, duration and outcome of the illness or condition. If ECNA has concerns about your fitness to work, any offer of membership may be subject to a satisfactory medical report.

Have you ever had:	YES	NO	Additional information to "Yes" responses:
Tuberculosis, asthma, bronchitis or chest complaints?	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain, heart condition or raised blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Blackouts, fits or attacks of giddiness?	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism or arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
Back trouble?	<input type="checkbox"/>	<input type="checkbox"/>
Typhoid, paratyphoid or dysentery?	<input type="checkbox"/>	<input type="checkbox"/>
Digestive or bowel disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, thyroid or other gland trouble?	<input type="checkbox"/>	<input type="checkbox"/>
Bladder or kidney trouble?	<input type="checkbox"/>	<input type="checkbox"/>
Dermatitis or skin trouble?	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>
Any other accident operation or illness?	<input type="checkbox"/>	<input type="checkbox"/>
Have you any reason to believe you may be infected by any communicable disease?	<input type="checkbox"/>	<input type="checkbox"/>
Any other current or recent medical condition or treatment, which might affect your attendance or performance at work?	<input type="checkbox"/>	<input type="checkbox"/>
Any illness or medical condition that prevent you from attending work or your normal duties or activities for more than one week during the past year?	<input type="checkbox"/>	<input type="checkbox"/>
Any physical disabilities including defect of sight or hearing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
How many units of alcohol do you drink per week?	<input type="checkbox"/>	<input type="checkbox"/>

(One unit = 1/2 pint of beer = 1 glass wine = 1 single whisky)

IMPORTANT-THESE ARE COMPULSORY IMMUNISATION REQUIREMENTS NHS SUPPLY:

Please give date of immunisation or vaccination for:

	Cert. Seen	Photo- copied		Cert. Seen	Photo- copied
Varicella (chickenpox)	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
Rubella (German Measles)	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis BCG	<input type="checkbox"/>	<input type="checkbox"/>			

LANGUAGES:			
Please list the language in which you are fluent (include your Mother tongue)			
LANGUAGE	PLEASE TICK IF FLUENT		
	SPEECH	READING	WRITING

WORK PREFERENCES:						
PLEASE TICK YOUR PREFERENCES FROM THE FOLLOWING:				YES	NO	
	DAY	EVENING	NIGHT	PRIVATE HOMES		
MONDAY						
TUESDAY				PRIVATE HOSPITALS		
WEDNESDAY						
THURSDAY				NHS TRUSTS		
FRIDAY						
SATURDAY				NURSING & RESIDENTIAL HOMES		
SUNDAY						
				CHALLENGING BEHAVIOUR		

BANK DETAILS:																		
BANK NAME AND ADDRESS:																		
ACCOUNT NAME:(YOUR NAME)																		
SORT CODE:				-		-		ACCOUNT NUMBER:										
BUILDING SOCIETY REFERENCE NUMBER:																		

DECLARATION

1. I confirm that I am 18 years of age, or over.
2. I acknowledge that neither ECNA, nor its employees, hold any responsibility or liability whatsoever for the services I provide, nor for the consequences of the provision of such services, including personal accident, damage to client’s property etc.
3. I declare that all information given is true and I understand that any false or misleading information may result in my removal from the ECNA Register of Members.
4. I agree that premiums for professional negligence indemnity insurance may be deducted from my fees.
5. I agree that information from this application form together with copies of my references may be passed on to the personnel departments of clients that I am introduced to by Elite Care Nursing Agency.
6. I have read and agreed to abide by the ‘Terms of Employment’.
7. I enclose **TWO** signed passport photographs of myself.
8. I understand that the company will be requesting a ‘Disclosure’ from the CRB, which I will be responsible for paying for.

Signed:.....

Date:.....

Name (printed):.....

**I confirm that I have had Varicella (chicken pox) and/or Herpes zoster (shingles)
(Delete as appropriate.)**

Signed:.....

Date:.....