



PROFESSIONALS  
CARE WITH DIGNITY AND EXCELLENCE

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Glasgow

G2 1RW

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## NURSES APPLICATION FORM

Please use CAPITAL LETTERS throughout.

### PERSONAL DETAILS

Title:

Forename:

Middle Name:

Surname:

Maiden Name:

Date of Birth:

Male ☐ Female ☐

Age:

National Insurance:

Address:

City/Town:

Country:

Postcode:

Home Telephone:

Mobile Phone:

Email Address:

Preferred Contact Method:

Are you willing to accept:

Morning calls ☐ Evening Calls ☐

Work Status:

Passport Number:

Nationality:

Eligibility to Work in UK:

Birth Certificate No:

Home office Letter Ref:

Place of Study (if Student):

Valid Driving License:

Yes ☐ No ☐

Endorsements:

Access to transport:

Yes ☐ No ☐

Willing to Travel for Work:

Yes ☐ No ☐

No ☐

Disabled Registration Number:

## EDUCATIONAL/PROFESSIONAL TRAINING

NMC Pin No:

Location Obtained:

Expiration Date:        /        /

[illegible]

***Please tick the nursing specialities of which you have significant, post training experience.***

***Please remember you will be held accountable for any missing information.***

Specialism	> 6 Months	< 6Months	1- 2 Years	2 Years +
Catheterization				
Peg Feed				
Stoma Care				
Drive syringe				
In charge Duties				
Hospitals				
Mental health				
Medical				
Care of the elderly				
Nursing Homes				
Residential Homes				
Venipuncture				

## EMPLOYMENT HISTORY

***Please give details of your past 5 years of continuous work history giving reasons(s) for any breaks in employment.***

From     /     /

To     /     /

Employer Name:

Address:

Telephone Number:

Main Contact:

Job Title:

Grade (if applicable):

Full-Time or Part-Time:

Salary:

Main Responsibilities:

Reason for Leaving:

From     /     /

To     /     /

Employer Name:

Address:

Telephone Number:

Main Contact:

Job Title:

Grade (if applicable):

Full-Time or Part-Time:

Salary:

Main Responsibilities:

Reason for Leaving:

From     /     /

To       /       /

Employer Name:

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Main Responsibilities:

Reason for Leaving:

From     /     /

To       /       /

Employer Name:

Address:

Telephone Number:

Main Contact:

Job Title:

Grade (if applicable):

Full-Time or Part-Time:

Salary:

Main Responsibilities:

Reason for Leaving:

## HEALTH DECLARATION

***I declare that I do not suffer from any illness that may hinder my performance as a Registered Nurse***

GP Surgery Name:

Address:

Telephone Number:

Email:

Applicant Signature:

## WORK PREFERENCE

***Please specify the area of care work you are interested in, tick all relevant boxes.***

NHS ☐

Private Hospital ☐

Nursing Home ☐

Residential Home ☐

*Please Specify:*

Short-term ☐

Long-term ☐

***Please specify your preferred days/times of work, tick all relevant boxes.***

Day Shift (Mon-Thurs) ☐

Night Shift (Mon-Thurs) ☐

Day Shift (Friday) ☐

Night Shift (Friday) ☐

Day Shift (Sat-Sun) ☐

Night Shift (Sat-Sun) ☐

Bank Holidays ☐

Dates of any current booked holidays:

Date that you can start work:

## REHABILITATION OF OFFENDERS ACT 1974

***Because of the nature of the work for which you are applying, this post is exempt from the provisions of section 4.2 Rehabilitation of Offenders Act 1974 (Exemption Order 1975). Applicants are therefore not; entitled to withhold information about convictions, which for other purposes are 'spent' under the provision of the Act in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action. Information provided will be kept confidential and use in relationship to the post applied for.***

Have you ever been convicted of a criminal offence?      Yes ☐      No ☐  
If yes, please specify:

Do you have any spent or unspent convictions? Yes ☐ No ☐  
If yes, please specify:

Have you instigated an enhanced disclosure within the last six years?    Yes ☐                      No ☐

*I hereby consent to West NAH Professionals LLP checking the details I have provided against the various data sources in order to verify my identity and process this application. These details may be used to assist other organisations such as CRB, and in identity purposes.*

Signature: \_\_\_\_\_ Date:        /        /

## REFERENCES

*Please provide the names and addresses of your two most recent employers who have the ability to comment on your work character and experience.*

Name of Reference:

Company Name:

Address:

Position:

Postcode:

City/Town:

Country:

Telephone No:

Email Address:

Start Date:     /     /

End Date:     /     /

Name of Reference:

Company Name:

Address:

Position:

Postcode:

City/Town:

Country:

Telephone No:

Email Address:

Start Date:     /     /

End Date:     /     /

## EMERGENCY CONTACT INFORMATION

Name of Emergency Contact:

Relationship:

Address:

Post Code:

Country:

Home Telephone:

Mobile Number:

Email Address:



### WORKING TIME REGULATIONS

***I have read and understood the working time regulations and I hereby consent that the working time limit shall not apply to my assignments.***

Print Name:

Signed:

Date:        /        /

### FINAL STATEMENT

***I declare that the information provided on this application is true to the best of my knowledge. I have read the terms and condition of engagement and agree to comply with the current Health and Safety at Work Act. I understand that my appointment is subject to the receipt of two satisfactory references and it subject to Enhanced CRB Disclosure. West NAH Professionals is free to make any other enquiries thy may find necessary relating to my application. I agree to respect the confidentiality of patients and clients and any other information I may have access to.***

Signed:

Date:        /        /