



Cornellius Healthcare



YOUR PERSONAL DETAILS

Title:	Surname:		
All other surnames or family names			
(Including maiden name & name changes including dates):			
First Name:			
Preferred name to be known by:			
Address:			
			Post Code:
Mobile Number:		Daytime Phone Number:	
Email Address:			
Do you hold a current full UK Driving Licence?			
Do you have any endorsements? If yes, please provide details?			Yes
			No

YOUR NURSING DETAILS

NMC Pin Number:	NMC Expiry Date:
NMC Part(s) of register:	
HCPC Number (ODP Only):	HCPC Expiry Date (ODP Only):

RIGHT TO WORK DETAILS

National Insurance Number:			
Your Nationality:	Date of Birth:		
Your Nationality: I am eligible to work in the UK and do not require a work permit:	YES		NO
I am already in possession of a work permit to work in the UK:	YES		NO

If other, please specify:

Cornellius Healthcare

Suite 3, Alderman Gatley House, Hale Top, Wythenshawe Civic Centre, Manchester, M22 5RQ

Company Registration: 08662725



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YOUR CLINICAL DETAILS

Please tick the boxes next to your speciality and clinical areas you have expertise in.
This will enable us to match your skills with the appropriate requirements.

General Nurse		Community		Critical	
Medical	<input type="checkbox"/>	Community General Nurse	<input type="checkbox"/>	A & E	<input type="checkbox"/>
Surgical	<input type="checkbox"/>	Primary Care Practitioner	<input type="checkbox"/>	Emergency Nurse Practitioner	<input type="checkbox"/>
Elderly Care	<input type="checkbox"/>	Health Visitor	<input type="checkbox"/>	ITU/HDU/CCU	<input type="checkbox"/>
Gynaecology	<input type="checkbox"/>	School Nurse	<input type="checkbox"/>	Oncology	<input type="checkbox"/>
Orthopaedics	<input type="checkbox"/>	Walk In Centre	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>
Palliative Care	<input type="checkbox"/>	Advanced Nurse Prescriber	<input type="checkbox"/>	Haematology	<input type="checkbox"/>
	<input type="checkbox"/>	Practise Nurse	<input type="checkbox"/>	Renal/Urology	<input type="checkbox"/>
	<input type="checkbox"/>	Nursing Homes	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>
Mental Health.		Paediatrics		Theatre	
Mental Health Nurse	<input type="checkbox"/>	Paediatric A & E	<input type="checkbox"/>	Recovery	<input type="checkbox"/>
Community Psychiatric Care	<input type="checkbox"/>	PICU	<input type="checkbox"/>	Scrub	<input type="checkbox"/>
Substance Misuse	<input type="checkbox"/>	Midwifery		Orthopaedic	<input type="checkbox"/>
Learning Disabilities	<input type="checkbox"/>	NICU/Neonatal/SCBU	<input type="checkbox"/>	ODP	<input type="checkbox"/>
Prison	<input type="checkbox"/>	Care/Support Staff:			
Specialist	<input type="checkbox"/>	HCA	<input type="checkbox"/>	Hospital	<input type="checkbox"/>
Sexual Health Nurse	<input type="checkbox"/>	CSW	<input type="checkbox"/>	Complex Care	<input type="checkbox"/>
Occupational Health	<input type="checkbox"/>	Community	<input type="checkbox"/>	Learning Disability	<input type="checkbox"/>

YOUR PROFESSIONAL CONDUCT

Have there been any proceedings of medical negligence or professional misconduct against you and have you ever been suspended or dismissed? YES/NO

If YES please supply details:

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REHABILITATION OF OFFENDERS ACT

Because of the nature of the work for which you are applying, section 4(2) and further orders made by the secretary of state under the provisions of this section of the rehabilitation of offender's act (1974) (exceptions) Order 1975 applies. Applicants are therefore required to give information about convictions which for other purposes are "spent" under the provisions of the Act. Any information given will be completely confidential and will be considered only in relation to positions to which the order applies. State YES or NO to questions 1 to 5.

1.	Do you have any convictions, cautions or bind-overs? (If YES please give details)		
2.	Have you ever had disciplinary action taken against you? (If YES please give details)		
3.	Are you at present the subject of criminal charges or disciplinary action? (If YES please give details)		
4.	Do you consent to Cornellius Healthcare requesting a police check and any appropriate references on your behalf?		
5.	Have you been police checked in the last three years? If so, by whom? (Please supply a copy)		

YOUR TRAINING, QUALIFICATIONS, APPRAISALS, AND REFERENCES

Mandatory Training Checklist (Practical & Online)

Moving & Handling		Basic Life Support		Intermediate Life Support		Advanced Life Support	
Complaints Handling		Handling Violence & Aggression		Fire Safety		COSHH	
RIDDOR		Caldicott protocols		Data Protection		Infection Control	
Lone Worker Training		Food Hygiene (Where required To handle Food)		Personal Safety (Mental Health & Learning Dis)		Resuscitation of the new-born (Midwifery)	
Interpretation of Cardiotocography traces (Midwifery)		Paediatric Life Support		SOCA/SOVA Level 3			

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YOUR DBS STATUS State YES or NO

Current DBS Disclosure (Formally known as CRB)?		
Clear?		
Issue Date:		
Disclosure Number:		
Is this certificate registered with the update service?		
Clear?		
Standard or Enhanced Disclosure:		
Enhanced with Children's barred list?		
Enhanced with Adults barred list?		
Is this certificate registered with the update service?		
Clear?		

IMMUNISATIONS

Please indicate which of the following immunisations you have been vaccinated against and include your vaccination reports when returning your registration: State YES or NO

EPP and Non EPP	Immunisation		
	Hep C		
	TB		
	Varicella		
	Measles		
	Rubella		
	Corona Virus -19 1		
	Corona virus19 2		
	Corona virus19 Booster		

	Immunisation	No Proof	Negative	Positive
EPP Candidates Only	Hep B			
	Hep B Antigen			
	HIV			



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YOUR NEXT OF KIN

Name of Next of Kin:

Relationship:

Phone Number:

CONFIDENTIALITY

I hereby declare that at no time will I divulge to any person, nor use for my own or any other person's benefit, any confidential information in relation to Cornellius Healthcare, or any of its respective clients, or in relation to any of their employees, business affairs, transactions or finances which I may acquire during the term of my agreement and / or engagement with Cornellius Healthcare.

DATA PROTECTION

I agree that Cornellius Healthcare retains the right to hold this registration and any other data required to process it and to pass on to any authorised third party the details held within, also to retain these details for as long as reasonably necessary in accordance with the Data Protection Act.

HEALTH DECLARATIONS

All applicants must complete a health questionnaire to enable us to establish your fitness for work. We would ask all OVERSEAS candidates to provide a medical statement from their GP or medical department confirming your state of health. Your details will be passed to our Occupational Health Doctors to establish your fitness for work. Please sign the declaration below to allow Cornellius Healthcare to release your information for inspection.

I (name), _____ consent to Cornellius Healthcare releasing my health and immunisation records for review to Cornellius Healthcare Qualified Occupational Health Adviser. I understand that based on this review I may be required to undergo a medical examination to establish my fitness for work. I confirm that I will immediately inform Cornellius Healthcare in confidence if I am HIV Positive, Hep B Positive or if I have AIDS in accordance with the Department of Health guidelines. I am aware of my obligations regarding MRSA contact and the need for screening. I agree to immediately inform Cornellius Healthcare should my general condition of health change. I will inform Cornellius Healthcare immediately if I discover that I am pregnant. I understand that withholding information or giving false answers may lead to dismissal. I also hereby consent to Cornellius Healthcare obtaining further information regarding my health from my GP or Occupational Health Department.

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HEPATITIS B

I have been advised at registration with Cornellius Healthcare, the importance of having the Hepatitis B vaccine. I acknowledge that I have been/am being vaccinated against Hepatitis B and will continue to maintain my immunity. I accept responsibility for my decision and I will ensure that I take all precautions to avoid contracting the illness and avoid accepting work within environments which are hazardous.

WORKING TIME REGULATIONS

For the purposes of the Working Time Regulations 1998 (as amended), I consent to work in excess of an average of 48 hours per week, averaged over 17 weeks. I understand that I may withdraw this consent by giving Cornellius Healthcare not less than three months' notice at any time. In addition, I also consent to work in excess of the maximum number of hours permitted to work at night under the directive. Please note you are under no obligation to sign either declaration.

Print Your Name

SIGNATURE:

DATE:

PERSONAL DECLARATION

- I confirm that the information given in this registration is, to the best of my knowledge, true and that an attempt to gain placement by deception is a criminal offence.
- 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 an Enhanced Disclosure from the Disclosure and Barring Service (DBS). I give my permission for Cornellius Healthcare to carry out a status check using the Update Service on my DBS Certificate and may be asked to provide a written statement regarding any information revealed on my DBS Certificate.
- I undertake to inform Cornellius Healthcare immediately should I be convicted of an offence in the future and will reveal ALL information contained in any Enhance Disclosure or police check.
- I undertake to inform Cornellius Healthcare immediately, if by virtue of their introduction, I receive an offer of permanent employment following a temporary assignment.
- I agree to respect the confidentiality of patients and any other information I may have access to, at all times.
- I am clear that Cornellius Healthcare cannot guarantee assignments and that they have no responsibility to pay for hours not worked no matter the situation.
- I have read, understood and agree to the conditions of work for temporary nurses contained within the Agency Workers Staff Handbook. Made available in hard copy or online as discussed.
- I give permission for any enquiries that need to be made to confirm such matters as qualifications experience and dates of employment, and for the release by other people or organisations of such information as may be necessary for that purpose.
- I agree that my personal details including my DBS Enhanced Disclosure may be viewed by third party auditors and potential employers.
- I give permission for the processing of the personal data contained in this form for employment purposes.

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REGISTRATION FORM DECLARATION

PLEASE READ THE COMPLETED REGISTRATION BEFORE SIGNING

I declare that by signing this form I am stating that I am legally entitled or allowed to work in the United Kingdom, with or without necessary permission from the Home Office or any other relevant authority. If I have secured permission to work, I have included copies of all documentation. I also acknowledge that if it is found that I am working without relevant permission, my employment will be terminated with immediate effect and all details passed to the relevant authorities.

I agree that Cornellius Healthcare retains the right to hold this Registration Form and any other data required to process it and pass onto any authorised third party and the details held within. I also agree to use all reasonable efforts to assist to comply with the Data Protection Act 1998.

In addition, I confirm that all the information provided is true and accurate and that I received and agree to Cornellius Healthcare Terms of Engagement and Agency Workers Staff Handbook.

Print Your Name

SIGNATURE:

DATE:

INDUCTION INFORMATION

Thank you for selecting Cornellius Healthcare as your agency of choice. Our team is committed to ensuring that your work requirements are met whenever possible. Cornellius Healthcare is a professional organisation specialising in providing high calibre nurses and carers to a wide range of health institutions.

Cornellius Healthcare continuing success depends on how well we work together. In order to achieve this, there has to be a set of agreed rules, guidelines and standards of conduct for all. These are fully explained in the Agency Workers Staff Handbook in conjunction with our Policy and Procedures. Copies of this are available on our website. The amount of work that we receive depends not only on us, but fundamentally on your performance. We therefore, have some basic expectations that are expected of you which are listed in our Agency Workers Staff Handbook.

I have taken time out to summarise some of these for you:

- Please make sure you arrive on time for your placement, or preferably 10 minutes early. If you are running late, you must ring us as soon as possible and advise us of this so that we can ring the client.
- You are our representative at the client; please ensure that you are wearing a valid photo ID badge and are presented in appropriate uniform and are able to perform your expected duties professionally and willingly at all times.
- If you cannot make your shift, you must give adequate notice in order for a replacement to be arranged.
- Cornellius Healthcare will only pay on receipt of an authorised timesheet. Please ensure you submit your timesheet to us every week. Weekly payments are made provided the timesheet arrives by Monday 12.00PM (Midday) for payment on Friday.

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In the case of National Health Service Professionals (NHSP) and other managed services where electronic timesheets are used, it is your responsibility to ensure the timesheet is submitted and approved by Monday 12.00PM (Midday).

Prior to your placement, it is your responsibility to familiarise yourself with the terms of your engagement that apply to your assignment. Please feel free to ask your contact within Cornellius Healthcare if there is anything that you are unsure of, as we are always here to support you.

Thank you for choosing Cornellius Healthcare.

please send your completed registration form to care@cornellius.org

APPENDIX B: REFERENCE DETAILS

Please supply us with two clinical professional references. One must be from your present or most recent employer and both must be from a senior grade to yourself who has supervised your work.

The second reference needs to be a previous employer unless you have been employed more than 3 years with your present or most recent employer. In such cases, then it must be another manager from your current or most recent employer. May we contact your referees: YES/NO

REFERENCE ONE

NAME:

POSITION:

WORK ADDRESS (INCLUDING POSTCODE)

WORK EMAIL:

TEL:

FAX:

PROFESSIONAL RELATIONSHIP TO THIS PERSON:

REFERENCE TWO

NAME:

POSITION:

WORK ADDRESS (INCLUDING POSTCODE)

WORK EMAIL:

TEL:

FAX:

PROFESSIONAL RELATIONSHIP TO THIS PERSON:

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