



# Nursing Employment Application

*Helping to  
place you in the right  
Healthcare position*

**+ NURSING 2000**

part of Nursing 2000 Limited

Head Office: 330-332 Streatham High Road | London | SW16 6HH

t: 0845 060 1234 | f: 020 8769 1733

e: [recruitment@nursing2000.co.uk](mailto:recruitment@nursing2000.co.uk)

w: [www.nursing2000.co.uk](http://www.nursing2000.co.uk)

# Employment Checklist

Thank-you for showing an interest in joining Nursing 2000, one of the fastest growing recruitment companies in the UK.

Please complete all the forms in this document and bring all the listed documentation below, to our head office in order to complete your application.

330-332 Streatham High Road, London, SW16 6HH.

We accept applications from 10am - 5pm Monday to Friday. If these times are not suitable please contact the office as we hold "Recruitment Saturdays" for people who cannot attend during the standard hours.

If you have any problems filling out the form, please contact our helpful office staff on **0845 060 1234** or if you prefer email **recruitment@nursing2000.co.uk**

## TO MAKE AN APPLICATION YOU WILL NEED TO BRING THE FOLLOWING:

### Trained Nurses

- NMC pin card
  - NMC statement of entry
  - 2 recent passport pictures
  - Recent enhanced CRB disclosure
  - 2 referee details of previous employers, including all contact details
  - Hepatitis B - You must provide a copy of the most recent pathology report showing titre levels of 100lu/l or above, or antigen status if titre level is below 100lu/l
  - Hepatitis B surface Antigen - Proof of a negative result
  - Polio, tetanus and diphtheria
  - Certificates of CPR, Fire & safety, manual handling within the last 12 months together with any other certificates that you have attained during your nursing career.
  - Proof of identity - passport, driving licence, utility bill
  - Proof of National Insurance number, i.e. card, P45, previous payslip
  - CRB fee is applicable (at current rate)
  - A recently updated CV / resume
- Details of your immunisation history. We require:**
- TB - Certificate from your GP / Occupational health department to say you have a scar or a positive skin test
  - Mumps, measles & rubella - Certificate of vaccination or blood test results showing titre levels demonstrating immunity
  - Varicella (chicken pox) - Certificate of vaccination or blood test results showing titre levels demonstrating immunity

### Midwives, Theatre Nurses & others performing EP procedures

- Proof of negative Hepatitis C
- Proof of negative HIV result

### Health Care Assistants

- All of the above, apart from details of professional registration.
- You can also provide any other certificates that you hold, for example, food & hygiene

## Employment Application for RN's / ODP's

To ensure your application can be processed please:

- Ensure the form is fully filled out
- Use black ink and complete in CAPITALS
- Ensure all the documents mentioned in the check list are supplied

**POSITION APPLYING FOR** \_\_\_\_\_**YOUR PERSONAL DETAILS**Title: Mr  Mrs  Ms  Miss  Other \_\_\_\_\_

Email Address: \_\_\_\_\_

Surname: \_\_\_\_\_

Do you hold a current driving licence: Yes  No 

First Names: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Nationality: \_\_\_\_\_

Any other names you may be known as including Maiden name:  
\_\_\_\_\_

National Insurance No.: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Next of Kin's Name: \_\_\_\_\_

Next of Kin's Address: \_\_\_\_\_  
\_\_\_\_\_

Postcode: \_\_\_\_\_

Next of Kin's Telephone No.: \_\_\_\_\_

Day Time Telephone No.: \_\_\_\_\_

Next of Kin's Mobile Phone No.: \_\_\_\_\_

Mobile Phone No.: \_\_\_\_\_

**YOUR PROFESSIONAL DETAILS**

NMC Pin Number: \_\_\_\_\_

HPC Number (ODP) \_\_\_\_\_

NMC Expiry Date: \_\_\_\_\_

HPC Expiry Date: \_\_\_\_\_

NMC Part(s) or Register: \_\_\_\_\_

ENB Courses held & date when attained: \_\_\_\_\_  
\_\_\_\_\_**DATES OF MANDATORY TRAINING**

COURSE:	TRAINED BY:	EXPIRY DATE OF CERT.
Moving & Handling		
Fire & Safety		
C.P.R. - Basic Life Support		
Cardiotocography for Newborns & Cartiotocograph traces		
Health and Safety including COSHH and RIDDOR, acts 1974 & 1999		
Infection Control		
Food & Hygiene		

**DETAILS OF YOUR TRAINING HISTORY**

NAME & ADDRESS OF TRAINING SCHOOL:	DATES FROM:	DATES TO:

NAME & ADDRESS OF TRAINING SCHOOL:	DATES FROM:	DATES TO:

## EMPLOYMENT HISTORY

- Please provide the last 10 years with the most recent first.
- If there are any gaps please explain.
- If you have a detailed C.V. this will be sufficient.
- Continue on a separate sheet if required.

Employers Name and Address: \_\_\_\_\_

Main Duties: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dates From: \_\_\_\_\_

Band (Grade): \_\_\_\_\_

Dates To: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

\_\_\_\_\_

Employers Name and Address: \_\_\_\_\_

Main Duties: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dates From: \_\_\_\_\_

Band (Grade): \_\_\_\_\_

Dates To: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

\_\_\_\_\_

Employers Name and Address: \_\_\_\_\_

Main Duties: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dates From: \_\_\_\_\_

Band (Grade): \_\_\_\_\_

Dates To: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

\_\_\_\_\_

## YOUR PASSPORT DETAILS

Your Current Visa Status (Please tick one):

If 'Other', please explain: \_\_\_\_\_

I am a British Citizen: \_\_\_\_\_

I have Permanent Residency: \_\_\_\_\_

I have indefinite leave to remain: \_\_\_\_\_

I am a European national: \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## YOUR CLINICAL SETTING PREFERENCES

Please tick the areas you would like to work:

A&E  Community  Elderly Care  General  Gynaecology  Health Visiting  Homecare  Nurse Prac.

ITU  Learning Disabilities  Liver ITU  Medical  Mental Health  Midwifery  Neonatal / PICU  ODP

Orthopaedics  Paeds  Practice Nursing  Recovery  Renal  SCBU  Surgical  Theatres

Urology  Other (Please Specify) \_\_\_\_\_

Please list the area that you would like to work, e.g. South London, Surrey etc.: \_\_\_\_\_

I am interested in FULL TIME WORK  PART TIME WORK

## PROFESSIONAL CONDUCT

Have you ever been suspended from the register or dismissed or have there ever been any proceedings of medical negligence made against you?

YES  NO

If yes, please supply the details: \_\_\_\_\_  
\_\_\_\_\_

## REHABILITATION OF OFFENDERS ACT

Because of the nature of the work for which you are applying, this post is exempt from the provisions of section 4.2 of the rehabilitation of Offenders Act 1974 (Exception Order 1975). Applicants are therefore not entitled to withhold information about convictions which for other purposes are spent under the provisions of the Act, and in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action. Any information given will be completely confidential and will be considered only in relation to an application for positions in which the Order applies and should be entered at the end of any particulars you give in support of your application. A copy of our written policy is available upon request. A criminal record will not necessarily be a bar to obtaining a position.

PLEASE PROVIDE ADDITIONAL INFORMATION WHICH YOU THINK MAY BE RELEVANT IN SUPPORT OF YOUR APPLICATION.

Have you ever been convicted of an offence? (NB the Rehabilitation of Offenders Act 1974) YES  NO

If yes, please supply the details: \_\_\_\_\_  
\_\_\_\_\_

You may be offered an opportunity to work within an Environment or establishment where you come into contact with children or other vulnerable groups, or your professional occupation may fall within certain expected categories where this is likely to apply, the Rehabilitation of offenders Act 1974 (exceptions) order 1975 requires us to ask you for additional information. A CRB disclosure (Criminal Records Bureau) may be required when this type of work is sought.

Do you have any previous convictions, whether "spent", or "unspent" within the Act, including any cautions, reprimands, final warnings, bind-over's or any convictions from overseas? YES  NO

If yes, please supply the details: \_\_\_\_\_  
\_\_\_\_\_

Do you hold an enhanced CRB disclosure that has been carried out in the past 1 year? YES  NO

If yes, please supply a copy: (Nursing 2000 follows the CRB Code of Practice recommendations April 2009. A copy is available upon request.)

## SECURITY CLEARANCE

Have you got a current security clearance? If so please give details below. \_\_\_\_\_  
\_\_\_\_\_

## YOUR REFERENCE DETAILS

- Please supply details of 2 professional clinical referees. Home addresses must not be used.
- One MUST be from your present employer and must be a senior band (grade) to yourself.
- You should have worked for both referees for at least 4 months where permissible.
- Please be advised that we will contact your referees as soon as we receive your application, unless otherwise advised.

### REFEREE 1

Name: \_\_\_\_\_ Daytime phone number: \_\_\_\_\_  
Position: \_\_\_\_\_ Fax number: \_\_\_\_\_  
Work Address: \_\_\_\_\_ Email Address: \_\_\_\_\_  
\_\_\_\_\_  
In what capacity was the referee known to you?: \_\_\_\_\_  
Postcode: \_\_\_\_\_ How long has this person known you?: \_\_\_\_\_

### REFEREE 2

Name: \_\_\_\_\_ Daytime phone number: \_\_\_\_\_  
Position: \_\_\_\_\_ Fax number: \_\_\_\_\_  
Work Address: \_\_\_\_\_ Email Address: \_\_\_\_\_  
\_\_\_\_\_  
In what capacity was the referee known to you?: \_\_\_\_\_  
Postcode: \_\_\_\_\_ How long has this person known you?: \_\_\_\_\_

### YOUR BANK ACCOUNT DETAILS

Your wages are paid directly into your bank account.

Address of Bank: \_\_\_\_\_

Name of Bank: \_\_\_\_\_

Branch: \_\_\_\_\_

Sort Code: \_\_\_\_\_

Account Holder Name: \_\_\_\_\_

Account Number: \_\_\_\_\_

I would like to be paid through a limited company and enclose the details:  I am self employed:

I wish to work on a P.A.Y.E. basis.  Please provide a P45 if we are to be your main employer.

### PRE-EMPLOYMENT DECLARATION OF HEALTH

Please answer all of the following questions accurately.

If you answer 'YES' to any, please provide details. It is your responsibility to inform Nursing 2000 immediately if any of the following changes:

HEALTH HISTORY:	YES	NO	DETAILS:
1) Have you knowingly been in contact with MRSA? If yes, were you swabbed and what were your results and dates?	<input type="checkbox"/>	<input type="checkbox"/>	
2) Have you ever had either a drug or alcohol problem?	<input type="checkbox"/>	<input type="checkbox"/>	
3) Have you got any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	
4) Have you got any impairments that may affect your ability to work safely?	<input type="checkbox"/>	<input type="checkbox"/>	
5) Is there any aspect of your medical history that an employer should know?	<input type="checkbox"/>	<input type="checkbox"/>	
6) Have you ever suffered any mental illness episodes and / or psychological problems, including stress related disorders?	<input type="checkbox"/>	<input type="checkbox"/>	
7) Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
8) Are you currently taking any prescribed medication?	<input type="checkbox"/>	<input type="checkbox"/>	
9) Are you currently receiving any treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
10) Have you any reason to believe that you may be infected by a high risk infection or disease?	<input type="checkbox"/>	<input type="checkbox"/>	

HAVE YOU EVER, INCLUDING YOUR CHILDHOOD, SUFFERED FROM OR RECEIVED TREATMENT FOR:	YES	NO
11) Chicken Pox or Varicella Zoster virus?	<input type="checkbox"/>	<input type="checkbox"/>
12) German Measles?	<input type="checkbox"/>	<input type="checkbox"/>
13) TB, Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
14) Hepatitis A, B or C / Jaundice?	<input type="checkbox"/>	<input type="checkbox"/>
15) Skin disorders, skin disease, skin reactions?	<input type="checkbox"/>	<input type="checkbox"/>
16) Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
17) Thyroid problems or other glandular problems?	<input type="checkbox"/>	<input type="checkbox"/>
18) Cardiovascular disorders or diseases or symptoms, including, high blood pressure, angina, low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
19) Epilepsy, fainting attacks?	<input type="checkbox"/>	<input type="checkbox"/>
20) Any kind of back or joint problems?	<input type="checkbox"/>	<input type="checkbox"/>
21) Respiratory symptoms, including asthma, bronchitis, pneumonia, pleurisy?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered 'YES' to any of the previous questions please explain below, referring to the question number that your comments relate to:

\_\_\_\_\_

**PRE-EMPLOYMENT DECLARATION OF HEALTH**

**YOUR VACCINATION HISTORY:**

In order to work for Nursing 2000, we require the following information:

Your GP's Name and Address: \_\_\_\_\_  
\_\_\_\_\_

	Can you provide proof	Date of last test	Result of this vaccination or test
TB, Tuberculosis			
Varicella			
Mumps, Measles & Rubella			
Hepatitis B			
Hepatitis B surface antigen			
Polio			
Tetanus			
Diphtheria			

**ADDITIONAL INFORMATION**

If you have any information that relates to your health that may affect your ability to work safely, please make a note here.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DECLARATION SECTION**

- I understand that if I provide Nursing 2000 with incorrect bank details this will delay payment
- I declare that all the information provided in my declaration of health is true and to the best of my knowledge. I also realise I must inform Nursing 2000 if there is any change to my health. Failure to do so could mean Nursing 2000 terminating my employment
- I give Nursing 2000 the permission to contact my GP to obtain further information, if so required
- I confirm that I have read the Nursing 2000 contract of services and fully understand the contents & have been given a copy
- I declare that under data protection law, Nursing 2000 retains the right to keep this application and any other information associated with this application and also to pass it on to any 3rd party. I also agree that Nursing 2000 can retain the details of my application for employment for as long as is reasonably necessary in accordance with the Data Protection Act 1998
- I also understand that I have to apply for a new Criminal Records Bureau Disclosure, CRB.
- I declare that I have received a copy of the Nursing 2000 staff handbook and have read and understood its contents

Signed by Employee \_\_\_\_\_ Date \_\_\_\_\_  
Print Name \_\_\_\_\_

# Trained Nurse's Skills

**Notes:**

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

<b>WOUND MANAGEMENT</b>	<b>Number 1</b>	<b>Number 2</b>	<b>Number 3</b>	<b>Number 4</b>	<b>Comments</b>
Aseptic technique					
3 Layer					
Removal of sutures					
Removal of clips					
Removal of staples					
Removal of drains:					
a) Redivac					
b) Closed drainage systems					
Drain dressing					
Change of vacuum drain					
Chest drain					
Prevention of pressure sores					

<b>RESPIRATORY MANAGEMENT</b>	<b>Number 1</b>	<b>Number 2</b>	<b>Number 3</b>	<b>Number 4</b>	<b>Comments</b>
O2 therapy					
Suctioning:					
a) Oropharyngeal					
b) Endotracheal					
Tracheostomy care:					
a) Suction of trachy					
b) Changing of tubes					
c) Changing dressing					
Chest drain					
Removal of drain tubes					
Care of ventilated patient					
Blood gas interpretation					
Obtaining blood gases					
Intubation					
Assisting in intubation					
BiPAP					

<b>ADMINISTRATION OF MEDICATION</b>	<b>Number 1</b>	<b>Number 2</b>	<b>Number 3</b>	<b>Number 4</b>	<b>Comments</b>
Oral					
Injection:					
a) IM					
b) IV					
c) SC					
Rectal administration					
Topical					
Eye drops					
Ear drops					
Cytotic drugs					

<b>IV MANAGEMENT</b>	<b>Number 1</b>	<b>Number 2</b>	<b>Number 3</b>	<b>Number 4</b>	<b>Comments</b>
Admin of drugs by continuous					
Admin of drugs by infusion					
Admin of drugs by injection					
Admin of drugs by direct (bolus)					
Admin of blood and other blood products					
Infusion pumps					
Syringe drivers					
CVP readings					
Venepuncture					
Arterial lines:					
a) Setting up					
b) Taking a sample					
c) Removal					

<b>RENAL MANAGEMENT</b>	Number 1	Number 2	Number 3	Number 4	Comments
Catheter insertion:					
a) Male					
b) Female					
Care of catheter					
Suprapubic catheter					
Nephrostomy tube					
Bladder lavage and irrigation					
Care of renal transplant patient:					
a) On peritoneal dialysis					
b) Haemodialysis					
c) Following surgery					

<b>NEUROLOGICAL MANAGEMENT</b>	Number 1	Number 2	Number 3	Number 4	Comments
Neuro obs and assessment					
Care of EP patient					
Care of a patient with:					
a) CVA					
b) Spinal cord injury					
c) Head injury					
d) Unconscious patient					
e) During and after LP					
f) Post neuro surgery					

<b>EMERGENCY CARE</b>	Number 1	Number 2	Number 3	Number 4	Comments
Suturing					
Plaster of paris					
Resus room working					
Trauma care					
Triage					
ATLS	<input type="checkbox"/> YES	<input type="checkbox"/> NO			
ENP	<input type="checkbox"/> YES	<input type="checkbox"/> NO			

<b>CARDIOVASCULAR MANAGEMENT</b>	Number 1	Number 2	Number 3	Number 4	Comments
Perform 12 lead ECG					
Cardiac monitoring					
Interp basic arrhythmais					
CPR					
Management cardiac arrest					
Carried out defibrillation					
Assisting with pacemaker:					
a) Swan-ganz					
b) Ballon pump					
Care of post MI					
Care of patient with CCF:					
a) Cardiac surgery					
b) Cardiac catheterisation					

<b>CARDIAC ARREST</b>	Number 1	Number 2	Number 3	Number 4	Comments
Manage a cardiac arrest					
Understand what drugs are used					
Use of ambu bag and airway					
Cardiac compressions					

<b>GASTROINTESTINAL</b>	Number 1	Number 2	Number 3	Number 4	Comments
Stoma care					
NG feed					
Care of NG tube					
Passed NG tube					
TPA					
Care of gastrostomy tube					

<b>OTHERS</b>	Number 1	Number 2	Number 3	Number 4	Comments
Barrier nursing					
MRSA prevention					
Care of confused patient					
NMC codes					

Type of work:  Full Time  Part Time  
 Hospital  Health Visiting  Practice Nurse  Community Nurse  Prison  Other \_\_\_\_\_

# Health Care Assistants HCA Skills

**Notes:**

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

SPECIALISM	Number 1	Number 2	Number 3	Number 4	Comments
Catheter Care					
Elderly care					
Fluid Charts					
Home Care					
Hospitals					
Learning disabilities					
Nursing homes					
Mental Health					
Nursery Nursing NNEB					
Observations:					
a) blood pressure					
b) Temperature					
c) Pulse					
d) Respirations					
Residential homes					
Schools					
Paediatrics					
Private homes					
Urinalysis					

## Equal Opportunities Monitoring

We are an equal opportunity employer and positively encourage applications from suitably qualified and eligible candidates regardless of sex, race, disability, age, sexual orientation, or religion or belief. To enable us to improve and monitor our employment processes, please complete the section below and note that this information is confidential and will be used only for the purpose of monitoring.

**SEX:** Please tick the appropriate box.

Male  Female  Transgender  Undisclosed

**DATE OF BIRTH:**

\_\_\_\_\_

**ETHNIC ORIGIN:**

**WHITE**

English  Scottish  Welsh  Irish

Other, please specify: \_\_\_\_\_

**MIXED**

White & Black Caribbean  White & Black African

White & Asian  Other, please specify: \_\_\_\_\_

**ASIAN**

Indian  Pakistani  Bangladeshi

Other, please specify: \_\_\_\_\_

**BLACK**

Caribbean  African

Other, please specify: \_\_\_\_\_

**CHINESE**

Chinese  Other, please specify: \_\_\_\_\_

**OTHER**

Please state: \_\_\_\_\_

Prefer not to answer this question

**NATIONALITY:**

\_\_\_\_\_

**DISABILITY:**

The disability discrimination Act 1995 defines disability as a "physical or mental impairment, which has a substantial and long term adverse effect on a person's ability to carry out normal day-to-day activities"

Do you consider yourself to be a disabled person?

Yes  No  Undisclosed

If yes, please give brief details of your disability: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SEXUAL ORIENTATION:**

Bisexual  Heterosexual  Homosexual

Undisclosed  Other, please specify: \_\_\_\_\_

**RELIGION or BELIEF:**

Anglican  Catholic  Other Christian

Protestant  Buddhist  Hindu  Jewish

Muslim  Sikh  Other, please specify: \_\_\_\_\_

**ELIGIBILITY TO WORK IN THE UK**

Changes to the Asylum and Immigration Act 1996, which came into force on 1st May 2004, mean we are now required to make basic document checks, to ensure potential employees are eligible to work in the UK. If we invite you to interview, we will ask for proof of your eligibility to work in the UK. This could be an in-date passport, National Identity Card or a photo card driving license with counterpart registered at your current address. If you do not have one of these, we will require a document giving you permanent National Insurance Number (for example, a P45, P60, NI card), together with one of the following: a birth certificate issued in the UK, or certificate of registration or naturalisation, or a Home Office document stating eligibility to remain in the UK.

Are you able to provide documentary evidence of your legal right to work within the UK?

Yes  No

# Nurses Induction

Name of agency worker \_\_\_\_\_ Qualification \_\_\_\_\_

	Yes	No	N/A	Comments
Is the application form complete?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has an I.D. badge been issued?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has the statement of employment been issued to & understood by agency worker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Staff handbook been given?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you explained the structure of Nursing 2000, i.e. the Directors, manager, booking consultants, accounts / payroll dept?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you explained how our on-call service works?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uniform policy been explained?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you explained that an annual health check is carried out by our occupational health dept & a pre-employment screening is required?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you explained the option for the agency worker to offer his/her services through a Limited company & how the agency worker can save tax by working through an umbrella company?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is the agency worker aware of Nursing 2000's: web address, where they can access regular newsletters/jobs etc, e-mail addresses, fax numbers & main office number?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is the agency worker aware of our appraisal processes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Explained the deadline for timesheets & how they should be filled out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Electronically sent / given handouts to the agency worker, details of Nursing 2000's policies & procedures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you explained Nursing 2000's bonus schemes to the agency worker including our generous "refer a colleague scheme"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Explained the Indemnity insurance weekly fee?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Explained what holiday rate the agency worker is entitled to?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Informed the agency worker that statutory training MUST be carried out yearly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

How do you rate the agency worker's nursing experience / knowledge? \_\_\_\_\_

Please comment on the agency worker's communication skills both verbally & written \_\_\_\_\_

Please comment on agency worker's clinical skills \_\_\_\_\_

I confirm that the agency member of staff has received an induction into how Nursing 2000 operates both internally and with our clients.

Nursing 2000 office staff \_\_\_\_\_ Signature \_\_\_\_\_ Position \_\_\_\_\_ Date \_\_\_\_\_  
(print name)

## Payroll/Admin Checklist

References sent?  Yes  No Date \_\_\_\_\_

Comment \_\_\_\_\_

References returned? Ref 1  Yes  No Date \_\_\_\_\_

Ref 2  Yes  No Date \_\_\_\_\_

NMC PIN & Quals confirmed  Yes  No Date \_\_\_\_\_

How CRB paid? (no cheque payments) \_\_\_\_\_

Date \_\_\_\_\_ Sent? \_\_\_\_\_

### Documents seen/verified & copied if appropriate

	Yes	No
• Passport - Verified & able to work in the UK	<input type="checkbox"/>	<input type="checkbox"/>
• Proof of national insurance number	<input type="checkbox"/>	<input type="checkbox"/>
• Existing CRB	<input type="checkbox"/>	<input type="checkbox"/>
• Proof of address	<input type="checkbox"/>	<input type="checkbox"/>
• NMC PIN card	<input type="checkbox"/>	<input type="checkbox"/>
• NMC statement of entry	<input type="checkbox"/>	<input type="checkbox"/>

Application on IQX \_\_\_\_\_

