PRIME HEALTHCARE SOLUTIONS

PERSONAL DETAILS:
Please print name as stated on your GMC/NMC certificate

Title:

Marital Status: Select

Date of Birth:

Forename(s):

Surname:

Other Names used since birth:

If so please provide documentary evidence to support i.e. Marriage Certificate ETC

National Insurance No:

Self-Assessment No:

CURRENT CONTACT DETAILS

House Number/Name:

Street Name:

Town:

County:

Post Code:

Country:

Home Tel No:

Mobile Tel No:

Email Address:

EMERGENCY CONTACT

Name:

Relationship:

House Number/Name:

Street Name:

Town:

County:

Post Code:

Country:

House Tel No:

Mobile Tel No:

Email Address:

IDENTIFICATION CHECKS

Please provide photo identification (e.g Passport Driving License, British Residence Permit) 2 x copies of proof of address (e.g household bills showing current address, dated within the last 3 months)

Do you hold UK Driving Licence? Yes ☐ No ☐ *If yes, please provide us with a copy*

IMMIGRATION STATUS

British/EU National Yes ☐ No ☐

Passport No:

Tier 1 VISA Holder Yes ☐ No ☐

Expiry Date:

Tier 2 VISA Holder	Yes ☐	No ☐
Tier 3 VISA Holder	Yes ☐	No ☐
Tier 4 VISA Holder	Yes ☐	No ☐
Other? Please specify		
Non-EU Doctors, Please confirm your eligibility to work in the UK as a Doctor	Yes ☑	No ☐

Please provide documentary evidence to support you immigration status

REGULATOY AUTHORITY

GMC/NMC/HCPC		Membership No:	
Please confirm whether you are currently under investigation by your Regulatory Authority or any other organisation?	Yes ☐	No ☐	
Have you ever been investigated by the GMC/GDC/NMC or any other organization	Yes ☐	No ☐	

**Please be advised that this is the responsibility of the applicant to inform Prime Healthcare Solutions of any change or restrictions to their registered professional body status immediately upon awareness or notification of any kind of investigation by either an NHS body, or other wider public sector body, or your relevant Professional and Regulatory Body For a detailed list of the regulatory authorities included within the definition of 'Regulatory Authority' please see our terms and conditions of engagement for doctors, nursing staff and allied healthcare professionals.*

Mentors / Appraisers Name:		Appraisers GMC/NMC No:	
Job Title:		Trust Name:	
Contact Tel Number:		Contact Fax Number:	
Email Address:			
Date of Last Appraisal:		Date of next Appraisal:	
Date of your Next Revalidation/Confirmation:			
(Doctors Only) Designated Body:			

PROFESSIONAL INDEMNITY INSURANCE*

Name of Insurance Company:	
Policy No:	

**Please ensure you provide a copy of your insurance Certificate*

EDUCATION AND PROFESSIONAL TRAINING*

List all professional qualification held and training courses undertaken pertaining to work within an Acute Hospital Trust, Mental Health Trust or Clinical Commissioning Group. In particular, please confirm details of your VTS. Professional qualifications and training will be verified. Continue on a separate sheet if necessary. Please provide photocopies of all certificates. (For convenience and where appropriate please state: See CV).

Qualification / Course	Institution Venue	From (Month/ Year)	To (Month/ Year)

**Please provide documentation to support*

ADDRESS HISTORY

Last 5 years address history required

ADDRESS 1

House Number/Name:			
Street Name:			
Town:		County:	
Post Code:		Country:	
Home Tel No:		Mobile Tel No:	
From:		To:	

EMPLOYMENT HISTORY

Please list your full employment history, starting with your most recent/ current
Please explain any gaps in your employment (over 1month) in the space provided.
Please Continue on a separate sheet if necessary.

Employer & Tel No:	Position Held:	Date From:	Date To:

WORK REQUIREMENTS & AVAILABILITY

Available from:		Available until:	
Dates unavailable to work:			

Please provide any further information regarding your avalability?

Please state the geographical preference in relation to location of work. Are you Prepared to travel/ stay away from home?

Please provide us with your nearest underground/railway station and bus route:

Do you have your own transport? Yes ☐ No ☐

Please List all the computer system with which you are familiar (e.g. Consult & Prescribe from).

PROFESSIONAL REFEREES

Please supply two recent professional referees from your current/last substantive post (ideally to cover the last 3 years) if this is not possible, please contact us to discuss suitable alternatives.

Referee 1

Name: Title:

House Number/Name:

Street Name:

Town: County:

Post Code: Country:

Home Tel No: Mobile Tel No:

Email address:

Capacity in which Known

Referee 2

Name: Title:

House Number/Name:

Street Name:

Town: County:

Post Code: Country:

Home Tel No: Mobile Tel No:

Email address:

Capacity in which Known

Can we contact your referees immediately? (Please tick accordingly) Yes ☐ No ☐

BANK AND BUILDING SOCIETY DETAILS

Bank/Building Society Name

Street Name:

Town: County:

Post Code: Country:

Account Holders Name(s):

Account No:

Sort Code:

CHECKLIST: DOCUMENTS TO BE COMPLETED & ENCLOSED

Please tick the relevant box when returning your pack.

Required Information

Completed Occupational Health Statement	☐	Certificates of Professional Qualification/Memberships/Diplomas	☐
Disclosure Barring Service Check	☐	Basic or Advanced Life Support	☐
CV (With no gap greater than 2 Weeks)	☐	Passport	☐
References (two up to date references)	☐	Where applicable, confirmation of eligibility to work in the UK.	☐
GMC/NMC Certificate (Original and Annual Certificate)	☐	Clear Photograph (Please email or post)	☐

Occupational Health - Evidence of Immunisation against:

For Exposure Prone Procedures (EPP) The bloods are required to be identity validated Samples (IVS) from a Bitish Laboratory

Measles	☐	Tuberculosis	☐
Mumps	☐	Hepatitis B	☐
Rubella	☐	Varicella	☐
Hepatitis C (EPP/IVS)	☐	HIV (EPP/IVS)	☐
Hepatitis B surface antigen (EPP/IVS)	☐		

Coronavirus Vaccination Status

Have you received your Covid-19 Vaccine?	Yes	☐	No	☐
1st Covid-19 Vaccine	Yes	☐	No	☐
2nd Covid-19 Vaccine	Yes	☐	No	☐
Booster Covid-19 Vaccine	Yes	☐	No	☐
Influenza Vaccine	Yes	☐	No	☐

TAX STATUS

Dear Prime Healthcare Solutions Recruitment,

Please note I wish to be paid gross for assignments with Prime Healthcare Solutions Recruitment. I will take into account my own income tax and national insurance contributions. If i have not provided my self-assessment number, it is because this is my first year of self-assessment. Once the Inland Revenue provide me with a self-assessment number it will be passed onto Prime Healthcare Solutions Recruitment.

Yours sincerely

Signature:
GMC/NMC No:(Delete as appropriate)

IMPORTANT INFORMATION

PLEASE SIGN THE DECLARATION ABOVE AND PRINT YOUR NAME ALSO AS INDICATED PLEASE ENTER YOUR GMC/NMC NUMBER TO ENSURE A SMOOTH PAYROLL SERVICE WE RECOMMEND THAT YOU COMPLETE THIS FORM FULLY AND RETURNWITH YOUR COMPLETED REGISTRATION FORMS.

DECLARATIONS

I, the undersigned hereby confirm and agree that the information giving in this application from is true and correct. i consent to my personal data CV being forwarded to clients or that of a third party for auditing purposes. I hereby consent for Prime Healthcare Solutions to verify the information relating to this application in order to comply with governed recruitment procedures and to satisfy the interests of patient safety. Furthermore, I consent for information held by Prime Healthcare Solutions about me to be viewed by the authority or any framework provider at their request and for the fulfillment of all regulatory requirements as necessary.

Termination of Employment

I understand that should any information come to light following any employment that I undertake, which shows that any information or medical information disclosed by me in this application was found to be misleading of false, Prime Healthcare Solutions has the right to terminate my contract with immediate effect.

Working Time Regulations

The Working Time Regulations 1998 ("The Regulations") require the Company to Limit your average weekly working time to 48 hours unless you agree with the Company that the Limit shall not apply to you. The Company wishes to have an agreement with you. It proposes an agreement (which will apply until terminated by notice) on the basis that:

The 48 hour Limit on average weekly Time will not apply to you

You may terminate the agreement (so that the 48 hour time limit would apply to you) by giving the Company 4 weeks written notice

Under the Regulations, the Company must keep records relating to your working time. This is the case whether or not you reach an agreement with the Company about waiving working time Limits

Mandatory Training & Appraisal

I understand that it is my responsibility to undergo an annual appraisal and attend mandatory training in the following discipline annually:

Moving and handling, health and safety (1974 & 1999), fire safety, Clostridium Difficile & MRSA COSHH, RIDDOR, risk incident reporting, complaintS handling, loan work training, data protection, infection control & prevention, handling violence and aggression conflict resolution, the Caldicott protocol, handling patient information, safeguarding children and adult, equality and diversity, dementia training, fraud awareness, level 2 basic life support, control and restraint / breakaway, intentions to practice (madwives only) newborn CPR / CTG (midwives only), Basic Food Hygiene (nursing only). Other mandatory training as required by the authorities.

Handbook

I declare that I have received, read and understood the Prime Healthcare Solutions introduction Handbook and that I am already train to NHS standard in all areas is described. Should I feel I required training in any area I will contact Prime Healthcare Solutions immediately. I acknowledge that I have been presented with the copy of the term and condition enclosed within the induction handbook and confirm I will abide by these terms and conditions

Data Protection & GDPR

The information that you provide on this form and on any CV will be used by Prime Healthcare Solutions to identify suitable locum opportunities. In providing this service to you, you consent to your personal data being included on a computerised database and consent to us transferring your personal details to our clients and other third parties as required including Framework insurance auditors. At all times. your personal data will be controlled in accordance with our GDPR obligations. A copy of our Privacy Statement is available

IR35 & Criminal Finance Act obligations.

In accordance with IR35 & Criminal Finance Act obligation, we are required to ensure that appropriate payroll deductions are being made on your behalf. As such you said to agree that assurance checks can be made in relation to your chosen payment method which include but are not limited to:

Provision of Umbrella Company copy pay slip both from you as an individual and also the Umbrella Company you have chosen to operate through. Any and all reasonable checks required by Prime Healthcare Solutions to satisfy its legal and regulatory

obligations under current and future IR35 & Criminal Finance Act legislation.

You sign to agree that you will only engage the services of a third-party Umbrella Company provider who satisfies the regulatory HMRC conditions of use..

Criminal Records Check

You are required to complete an enhanced DBS Disclosure. Prime Healthcare Solutions will send to you via email and electronic link in order that you can complete and return this to us promptly.

If registered with DBS Update Service, I provide Prime Healthcare Solutions with authority & consent to apply for a DBS update check, I sign to declare that to the best of my knowledge, I am unaware of any spent or unspent previous convictions subject to The Rehabilitation of Offend-ers Act 1974 (exceptions) order 1975 (amended) (England and Wales) order 2013, D.I 2013/1198

Have you undertaken a Disclosure and Barring Check (DBS) within the past 12 months	Yes ☐	No ☐
If so by who?		
Date you were last checked?		
Have you been convicted of a criminal offence, been bound over or cautioned or are you currently the subject of any police investigations? Please tick accordingly.	Yes ☐	No ☐

If yes, please provide details below including date, offence and authority / country which dealt the offence: (if required Please continue on a separate sheet)

Nature of incident:	
Date:	
Outcome:	

Failure to declare an incident or occurrence as a described may require us to exclude you from our register or terminate an assignment if the incident or occurrence is not declared but later comes to light.

Rehabilitation of Offenders Act 1974 (exceptions) Order 1975

You are required to disclose details of all criminal offences, suspension cautions and convictions including where you have been party to a criminal investigation or prosecution without formal outcome and from which any convictions are spent or remain unspent. This information may be shared with third parties and in providing the disclosure you accept that the information may be disclosed as required under law or any other relevant legislation. The information given

will be treated in the strictest of confidence and only taken into account where in reasonable opinion of Prime Healthcare Solutions the offence is relevant to the post to which you are applying. Include all relevant convictions other than minor offences such as parking fines and speeding tickets.

Changes to your Circumstance

It is important that you tell us as soon as reasonably possible if your circumstance change or if any of the information shown in your application has changed during your contact / period of work with Prime Healthcare Solutions.

Signed by candidate:

Name:

Date:

Regulatory Body Number
GMC/GDC/NMC:

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