

**O****R C H A R D M E D I C A L**

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## APPLICATION FORM

<b>Surname:</b>		<b>First Name/s:</b>	
<b>Address:</b>			
		<b>Postcode:</b>	
<b>Home Tel:</b>		<b>Mobile:</b>	
<b>DOB:</b>	/ /	<b>Email:</b>	<b>Nationality:</b>

<b>Next of Kin:</b>		<b>Contact No:</b>	
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### EDUCATION / TRAINING

Institution	Course/Degree	From	To	Grade

### PROFESSIONAL MEMBERSHIPS (e.g. HPC, BAOT, CSP )

Body	Membership No.

**PREVIOUS EMPLOYMENT**  
Please use additional sheets if required

Employer Name and Address	Clinical Areas/Job Description	From	To

**PROFESSIONAL REFEREES**

<b>Name/ Position</b>		
<b>Address</b>		
<b>Telephone</b>		
<b>Fax</b>		
<b>Email</b>		

**MANDATORY COURSES - please tick**

Mandatory Course	Date Last taken
Fire Safety <input type="checkbox"/>	
Health & Safety <input type="checkbox"/>	
Moving & Handling <input type="checkbox"/>	
COSHH & RIDDOR <input type="checkbox"/>	
Basic Life Support <input type="checkbox"/>	
Infection Control <input type="checkbox"/>	

**DRIVING LICENCE**

<b>Do you hold a current, full UK driving Licence?</b>	
<b>Do you have access to a car for work?</b>	

## MEDICAL HEALTH

Please state any Medical Conditions which an employer would wish to know about

Please state details of any medication you are currently taking

### IMMUNISATIONS - please attach evidence

Inoculation	Yes/No	Date of Inoculation
Rubella		
Varicella (self declare)		
Hepatitis B		
Hepatitis C		
Tuberculosis(Heaf test of visible evidence)		
HIV		

### CRIMINAL CONVICTIONS

#### Rehabilitation of Offenders Act 1974

Due to the nature of the work for which you are applying, this post is exempt from the act. Applicants are not entitled to withhold information about convictions which for other purposes are spent under the act. Any information given will be completely confidential and will be considered only in relation to the application for positions to which the act applies.

If you have ever been convicted of any offence please give details below. If you have no such convictions, please write NONE.

	Yes/No	Date issued	Disclosure No.
Criminal Records Bureau enhanced disclosure			

### EQUAL OPPORTUNITIES ETHNIC MONITORING

<input type="checkbox"/> African	<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> Caribbean
<input type="checkbox"/> Chinese	<input type="checkbox"/> European (EU Member)	<input type="checkbox"/> European (Non EU Member)
<input type="checkbox"/> Indian	<input type="checkbox"/> Pakistani	
<input type="checkbox"/> Other (Please specify)		

Where did you hear about Orchard Medical?

#### HAVE YOU ENCLOSED?

Immunisation Certificates	<input type="checkbox"/>
Mandatory Courses Certificates	<input type="checkbox"/>
CRB Disclosure	<input type="checkbox"/>
Driving Licence (where required)	<input type="checkbox"/>
HPC Certificate	<input type="checkbox"/>
Degree Certificate	<input type="checkbox"/>
2 photo's for ID badge	<input type="checkbox"/>
Visa details (Non EEC)	<input type="checkbox"/>

#### DECLARATION

I have read the Staff handbook available for download from [www.orchardlocums.com](http://www.orchardlocums.com) member's section and understand that it forms part of the Terms and Conditions.

I undertake to inform Orchard Medical immediately if I am engaged through an introduction by Orchard, including the offer of permanent employment following a temporary assignment.

I declare that all the answers and information provided in this application are true.

Therapist Signature	Date