

APPLICATION FORM

Surname:		First name:	
Date of birth:		GMC STATUS:	Registered/in progress/not registered
Postal Address:			
Postcode:		Fax:	
Telephone:		Email:	
Mobile (cell):		National Insurance number:	
Adult Advanced Life Support (Date completed or booked):	YES/NO		
Paediatric Advanced Life Support (Date completed or booked):	YES/NO		

BANK DETAILS:

Name of Account holder:	
Bank of Building Society:	
Address	
Sort Code:	Account Number:

BASIS OF RIGHT TO WORK IN UK

On what basis are you entitled to work as a doctor in the UK?	<ul style="list-style-type: none"> ▪ EU Citizen <input type="checkbox"/> ▪ Work Permit <input type="checkbox"/> ▪ Permit-free visa Spouse of an EU citizen <input type="checkbox"/> ▪ Right of abode in UK <input type="checkbox"/>
Please submit the following evidence (originals or copies of):	<ul style="list-style-type: none"> • passport identification pages and/or proof of Nationality • Residency status page of passport or proof of UK Residency • Work Permit page of passport or Work Permit • Permit-Free Training page of passport or Permit

AVAILABILITY

Starting: / During weeks or months of: / In these localities:	
Rota: 1 in 2/ 2 in 3 / other	Available from:
Nights, Weekends	
Sessions	
Holidays:	
Full-time:	
At Grades:	

OCCUPATIONAL HEALTH QUESTIONNAIRE

NHS trusts and hospitals require a health statement from you. The information given is confidential and will only be used in connection with employment with Cape Medical Services Limited and may be sent to prospective hospital clients.

IMMUNISATION HISTORY

Have you been immunised against the following:

TUBERCULOSIS	YES/NO	DATE
POLIO	YES/NO	DATE
TETANUS	YES/NO	DATE
RUBELLA (GERMAN MEASLES)	YES/NO	DATE
HEPATITIS A	YES/NO	DATE
HEPATITIS B	YES/NO	DATE

HEPATITIS B STATUS: Immune / Not immune / Borderline
 RUBELLA B STATUS: Immune / Not immune / Borderline
 HIV STATUS: Tested/Not tested Result: Negative/Positive

Date of last Chest X-Ray: _____ Result: _____

BASIC MEDICAL HISTORY

If you answer yes to any of the following questions, or you are currently taking any medication, please provide further information.

	YES	NO
Is there any aspect of your state of health that may restrict or impair your ability to work as a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
Is there any aspect of your medical history that an employer should or may wish to know?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been refused or retired from work on health grounds?	<input type="checkbox"/>	<input type="checkbox"/>
Are you under the care of a hospital doctor, attending or waiting for any hospital in- or out-patient treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever suffered from mental illness/depression, alcohol or drug dependency?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been refused life insurance or cover?	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently or regularly taking any medication, special diets or injections? If yes, please detail below:		
Do you or have you ever suffered from or received treatment for any of the following:		
Respiratory disorders or diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disorders or diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal disorders or diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disorders or diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disorders or diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Dermatological disorders or diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine disorders or diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Bone or Joint disorders or diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Haematological disorders or diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Infective disorders or diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Stress related, disorders or diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or Drug related disorders or diseases?	<input type="checkbox"/>	<input type="checkbox"/>

INFECTION RISK:

I believe that I am/am not carrying any infection that could pose a risk to patients. I understand my responsibilities as set out in "Duties of a Doctor" (General Medical Council) to have all necessary tests if I think I have or am carrying a serious communicable condition. I agree to act on the advice of a suitably qualified colleague about necessary treatment and/or modifications to my clinical practice. I also understand that I must take and follow advice from a consultant in occupational health or another suitably qualified colleague if a condition or illness could affect my judgement or performance as a medical practitioner.

I declare that the above information is true and complete and understand that withholding information may result in termination of my contract of employment by Cape Medical Services Limited.

Signed:	
Name:	
Date:	
GMC number:	

PRE-EMPLOYMENT QUESTIONNAIRE

NHS trusts and hospitals require a statement from you. The information given is confidential and will only be used in connection with employment with Cape Medical Services Limited and may be sent to prospective hospital clients.

DECLARATION: REHABILITATION OF OFFENDERS ACT 1974 (Exceptions Order 1975)

The above-mentioned Act permits persons in certain circumstances to ignore offences committed in the past, when asked to give details of previous convictions. However, due to the nature of the work you are contracted to perform, this post is exempt from the provision of section 4(2) of the Rehabilitation of Offenders Act 1974 by virtue of the Rehabilitation of Offenders Act 1974 (Exemption Order 1975) which makes it illegal for medical practitioners to withhold details of any offence(s) for which they have been convicted. Any information given will be regarded as strictly confidential and failure to disclose such convictions may result in termination of your contract of employment by Cape Medical Services Limited.

I hereby declare that I have stated any criminal convictions below in accordance with the above named Act.

Signed	_____
Name	_____
Date	_____
GMC number	_____

Please list below any offences relating to the above Declaration.

MEDICAL INDEMNITY

For the purposes of arranging appropriate medical indemnity cover for working in the UK, doctors are asked to complete the following section. If you answer yes to any of the following questions, please provide further information below.

	YES	NO
Are you currently, or have you ever been, the subject of any Professional Misconduct proceedings?	<input type="checkbox"/>	<input type="checkbox"/>
Has a claim for compensation ever been made in respect of your professional medical practice?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been refused medical indemnity insurance or cover?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a member of a professional indemnity organisation?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please state the organisation and membership number:		

CURRICULUM VITAE DECLARATION

I hereby certify that the information given in my Curriculum Vitae is correct and complete to the best of my knowledge and understand that any misleading statements, failure to disclose information or deliberate omissions will be regarded as grounds for withdrawal of offer or subsequent disciplinary action which may result in dismissal. I also authorise Cape Medical Services Limited to update my Curriculum Vitae in respect of the following areas:

- Qualifications, (providing copies of such qualifications are provided by the doctor)
- Work experience history, particularly employment carried out through Cape Medical Services Limited.
- Membership details of relevant professional organisations.

Cape Medical Services Limited agrees to discuss any such changes with the doctor concerned and warrants to provide each doctor with the updated details for confirmation.

Signed	
Name	
Date	
GMC number	