



APPLICATION FORM

Personal Details

Surname:	Title:	
Forename(s):	Gender:	
Date of Birth:		
Speciality:	Qualifications:	
Home address:		
	Postcode:	
Home tel:	Work tel:	Bleep:
Mobile tel:	Email:	
Nationality:	Country of origin:	
Next of Kin:	Contact Number:	Relationship:

Availability

Have you ever worked in the UK before? Y / N

If YES, when and in which PCT(s)?

Are you registered with the General Medical Council (GMC)? Y / N Reg no:

Are you registered on the General Practitioners register? Y/N

If YES, are you on the Specialist Register? Y / N

Are you eligible to work in the UK? Y / N Expiry:

If YES, please provide details:

From what date would you be available to start work and for how long?

What type of work are you seeking? Fulltime Locum Y / N Ad-hoc Locum Y / N Permanent Y / N
OOH's Locum Y/N

In which geographical areas would you prefer to work?

Would you be prepared to stay in accommodation away from home for work? Y / N

Are you covered for Professional Indemnity? Y / N

Name of organisation: Policy number:



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Further Training & Qualifications

Do you have a specialist qualification in substance misuse?

Please list the computer systems you are familiar with:

Do you have any other specialist interests?

Payroll Details

I intend to work with the GP Agency on a PAYE basis Limited Company basis*

Company name:

Reg. No.:

* Please note: GP Agency will not make payments to any company based offshore

Designated account for payments

National Insurance Number: _ _ _ _ _

Bank / Building Society Name:

Account Name:

Sort:

Account Number:

Building Society Ref No.:

Please ensure your booking consultant is aware of your preferred payment method at time of placement.

Data Protection

The GP Agency is registered within the Data Protection Commissioner as a "Data Controller" within the terms of the Data Protection Act 1998 for the purposes of the collection, storage and use of personal data for the purposes set out below. Personal information provided by you ("Your Data") is collected and used within the provisions of the Data Protection Act 1998. Personal Data that is exempt from notification under the data Protection Act is also processed. The foregoing companies will be Data Controllers in respect of Your Data. If you would like to know what personal information relating to you is being held by us then please send a written request to The Data Controller, GP Agency, 2 Fruit & Wool Exchange, Brushfield Rd, E1 6EU together with a payment of £10 asking for a description of the personal data held.

Your Data will be collected and retained in both hard copy and on a contact database. This will be managed by the GP Agency. It will be used to analyse and evaluate the information provided by you. It will be used for staff administration, advertising, marketing & public relations, accounts & records, consultancy & advisory services. Your Data will be disclosed to the GP Agency for the administration of your application and will be used to provide you with the service you registered for – to find you work. Only current authorised GP Agency employees will have access to this data. If the GP Agency wishes to send your application and personal details to a potential employer or third party in order to find you a job, the GP Agency will contact you first and obtain your permission before your details are sent.

In addition Your data may be used for the promotion and delivery of the GP Agency services. Your Data may also, from time to time, be disclosed to other Pathology Group companies and may be used for the promotion and delivery of their services. If you do not wish Your Data to be disclosed to such other organisations then please tick here

The accuracy and completeness of Your data submitted is entirely your responsibility.



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OCCUPATIONAL HEALTH MEDICAL QUESTIONNAIRE

CONFIDENTIAL

Information contained within this document is governed by the Data Protection Act 1998. Disclosure of information is only with your informed written consent. Recommendations to your employer will be directed to essential information regarding your health and the hazards and risks of your employment and with due reference to other relevant statutory requirements and professional practice.

Personal Information			
Title	Surname	First names	DOB
Home Tel:	Work Tel:	Mobile:	
Home Address:		GP Address:	

Health Checks	
When was the last time you visited your GP?	Date:
What was the reason for this (If happy to discuss)?	

(If the results were abnormal please provide details in the space below)

Details:

Basic Health History		
<u>If your answer to any of these questions is YES or if you are currently taking any medication please provide details in the space below</u>	Yes	No
Is there any aspect of your health which may restrict your ability to work	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently or regularly taking any medicines, tablets, special diets, or injections	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Is there any aspect of your medical history which an employer should or might wish to know	<input type="checkbox"/>	<input type="checkbox"/>
Do you require any adjustments to your working environment to undertake your chosen occupation	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any conditions of vision, hearing or speech which might affect your ability to work	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever suffered from any mental illness/depression or alcoholism or drug dependency	<input type="checkbox"/>	<input type="checkbox"/>
Are you attending any hospital for treatment or are you currently on a waiting list for treatment	<input type="checkbox"/>	<input type="checkbox"/>

<u>Do you now, or have you ever, suffered from or received treatment for</u>	Yes	No
Respiratory (including asthmatic or allergic) symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Neurological (including epileptic) symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>



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Genitourinary symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Skin symptoms symptoms, disorders, diseases including reactions to gloves and glove powder	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine (including diabetic) symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Haematological symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent sore throat (including treatment for MRSA infections)	<input type="checkbox"/>	<input type="checkbox"/>
Bone or Joint symptoms, disorders or diseases (including back pain)	<input type="checkbox"/>	<input type="checkbox"/>
Imunno-deficiency symptoms e.g. HIV positive diseases or disorders	<input type="checkbox"/>	<input type="checkbox"/>
Stress related disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Drug related symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Overseas travel symptoms, disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>

Immunisation History

Have you have any of the following immunisations	Yes	No	Notes
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	
Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	
BCG Vaccination	<input type="checkbox"/>	<input type="checkbox"/>	
MMR x 1	<input type="checkbox"/>	<input type="checkbox"/>	
MMR x 2	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had shingles or chicken pox?	<input type="checkbox"/>	<input type="checkbox"/>	

HIV / AIDS (NON EXPOSURE PRONE CANDIDATES ONLY)

Have you had a HIV blood Test	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date	Result:
Do you have reason to believe that you may have been or be exposed to HIV infection? If yes please detail:				
IMPORTANT A health care worker who has any reason to believe they may have been exposed to infection with HIV, in whatever circumstances, must seek and follow confidential advice from the Occupational Health Services. Failure to do so, may breach the duty of care to patients.				

Proof of Immunity (Please send the following)

Hepatitis B Certificate	You must provide a copy of the most recent pathology report showing titre levels of 100IU/l or above or evidence of a negative surface antigen test .The report must be an identified validated sample. (IVS)
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DECLARATION

The information supplied is true to the best of my belief. I agree to inform my employer of any health problems prior to been placed so that my health and safety can be protected whilst at work.		
Name	Signature	Date

If you require declaration forms these can be found at the following link:

<http://www.healthierbusinessukltd.co.uk/forms.doc>



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Equal Opportunities

The GP Agency is committed to equal opportunities and requires that none of its candidates are discriminated against or discriminate on the grounds of sex, race, colour, national origin, age, religion or disability.

Professional Conduct

Rehabilitation of Offenders Act 1974

Applicants for locum positions are exempt from the provision of section 4(2) of the Rehabilitation of Offenders Act 1974.

(Exemptions / Amendments) Order 1985 Applicants are therefore not entitled to withhold information about any convictions which for other purposes are 'spent' under the provision of the Act. Any information given will be completely confidential and will be considered in relation to an application for the positions to which the order applies.

Have you ever been convicted of a criminal offence, been bound over or cautioned or are currently the subject of any police investigations, which might lead to a conviction, an order binding you over or a caution in the UK or any other country?

Y / N

If the answer is YES, please contact us for advice

Please sign and date

Signed:

Date:

Fitness to Practice

Have you ever been the subject of professional misconduct proceedings or suspensions from an employer, or are such pending or threatened against you either in the UK or abroad?

Y / N

If YES please give details (attach additional sheet if required)

Disclosure

When working within the NHS you are required to provide an enhanced disclosure which is obtained from the Criminal records Bureau (CRB).

Do you have such a Police check issued within the last 12 months?

Y / N

It will be necessary for the GP Agency to apply for a new disclosure prior to commencement of work.

You must inform the GP Agency if you are convicted of an offence at any time during or after your registration with them.

48 Hour Working Week Opt-Out

Subject to limited exceptions, the UK Working Time Regulations require that a worker's average working time must not exceed 48 hours per week. You may accept as few or as many hours per week as you wish, subject to statutory limitations and in case you should wish to work more than an average 48 hours per week, please select yes below to give your consent.

I agree that I may work for more than an average of 48 hours per week. If I change my mind, I will give the GP Agency two weeks' notice in writing to end this agreement.

I hereby agree that the Working Week Limit shall not apply:

Y / N

Friends and Colleagues

The GP Agency is always keen to speak with the best people in their chosen disciplines. Please take the time to list the names and contact details of any friends or colleagues who you think may be interested in learning about how we can assist them in their careers, either in the UK or abroad:



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Declaration

I declare that the statements on this form are true and complete to the best of my knowledge and belief and I am aware that any false statements may affect my application. I will immediately notify the GP Agency of any changes to statements made on this form.

I am permitted to work in the United Kingdom.

I am aware of the GMC's statement with regard to serious communicable disease including HIV / AIDS, TB and Hepatitis C, and the need to protect patients and myself from infection risk.

I understand that my health statement will be processed by the GP Agency and retained by them. Details of my health record will not be submitted to any Trust without my prior consent. I give permission for information on my vaccination status, including any accompanying documents or reports to be used by the GP Agency in securing a position on my behalf.

I understand that my registration is subject to receipt by the GP Agency of all required documentation including but not limited to two satisfactory references and an enhanced CRB disclosure.

I acknowledge and accept the relevant Terms and Conditions of Engagement sent together with this application.

Permission to View File: From time to time, the GP Agency will be required to allow authorised third parties to inspect your file to assist with and ensure compliance with the National Framework Agreement and the NHS Code of Practice for Recruitment Companies. I permit the GP Agency to allow my file to be viewed by authorised third parties for this purpose explained.

Signed:

Date:

Thank you for registering with the General Practice Agency Limited.



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