



Nurse Application Form

Thank you for your enquiry regarding work with Cpl Healthcare incorporating Servisource Healthcare

Cpl Healthcare incorporating Servisource Healthcare place Nurses in numerous Hospitals and Health Care Organisations throughout Ireland, covering long-term, medium and short-term positions. It is our company policy to provide a consistent and quality service by matching the individual needs of both our nursing staff and our client organisations. Our office is open from 07:00 to 21:30, 363 days of the year to provide a quality service through a team of dedicated professionals.

Please find enclosed our application pack and a guide containing everything from payment information to behaviour guidelines. Please fill in the relevant details in the application pack and send it back to us with as much information as you can provide. A checklist of requirements is listed on the following page to assist you.

Please sign and date the application and return it to our offices at:

Cpl / Servisource Healthcare, 2nd Floor, 49 St Stephens Green East, Dublin 2

Cpl / Servisource Healthcare, 10/11 Steamboat Quay, Dock Road, Co. Limerick

Cpl / Servisource Healthcare, Block 3, Quayside Business Park, Mill Street, Dundalk, Louth

Cpl / Servisource Healthcare, 4 Bruach Na Laoi, Union Quay, Cork

Cpl / Servisource Healthcare, 16a Sandyford Business Centre, Bohermore, Galway

In the meantime, if you have any queries regarding any aspect of our recruitment, please call our Recruitment Department direct on **0818 365 100**.

Once again, thank you for your enquiry and we look forward to receiving your application in the near future.

Kind Regards,

Cpl Healthcare incorporating Servisource Healthcare

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The following documentation is required to be returned with your signed application form:

- Copy of current registration with An Bord Altranais
- Copy of Garda National Immigration Bureau Card (where applicable)
- Copy of passport
- 3 nominated clinical nurse referees
- CPR Certificate valid within the last two years
- Patient Moving and Handling Certificate valid within the last two years
- Infection Control Certificate valid within the last 2 years
- Non Violent Crisis Intervention / CPI Certificate valid within the last 2 years
- Elder Abuse Certificate valid within the last 2 years
- Fire Safety Certificate (optional)
- Two passport photographs (please sign the back of your photograph)
- Full Occupational Health Report
- Copy of certificate of Nursing Qualifications
- Copy of Union Membership
- Copy of current IV Policy Certificate
- Completed Garda Vetting Form
- €10 cheque / postal order for Garda Vetting process
- Curriculum Vitae.

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Personal Details

First Name:		<u>ATTACH SIGNED</u> <u>PASSPORT</u> <u>PHOTOS</u>
Surname:		
Previous Name:		
Address		
Mobile No.		
Home No.		
Work No.		
Email Address		
Gender		
Date of Birth		
PPS Number		
Next of Kin		

Do you hold a Garda National Immigration Bureau card?	Yes	No
If Yes please state stamp number and expiry date		
Please state start and end date of permit/visa	Start date: __ / __ / ____	End date: __ / __ / ____

How did you hear about our Agency?	Newspaper	Nursing Magazines	Internet	Friends	Other

Preferred Healthcare Organisations you wish to work in	
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Education

Nurse Training Hospital	
Phone No.	From To
Dates	
Qualifications Obtained	

Education part 2 – for dual /multi registered nurses

Nurse Training Hospital	
Phone No.	From To
Dates	
Qualifications Obtained	

Certification

An Bord Altranais PIN	
Qualification Type	
Name in which you are registered with An Bord Altranais	
Union Membership	
Union PIN	
Date of last Moving and Handling Course	
Date of last CPR Course	
Date of last IV study	
Preferred hospital you wish to work in	

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Employment History & References

- We require names and contact details of **your referees from your current and most recent employment.**
- Referees must be of CNM 1 level or higher.
- One reference must be from your **current or most recent employer**
- Any offers of a post is subject to satisfactory references

Current / Most Recent Employment

Healthcare Organisation		
Location		
Ward		Position Held
Date	To:	From:
Months in Post		
(1st) Referee's Name From Current Position or Most Recent Employment		
Referee's Position		
Referees Contact Details Phone/ Fax / Email		

Previous Employment:

Healthcare Organisation		
Location		
Ward		Position Held
Date	To:	From:



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Months in Post	
(2nd) Referee's Name From Current Position or Most Recent Employment	
Referee's Position	
Referees Contact Details Phone/ Fax / Email	

Previous Employment:

Healthcare Organisation		
Location		
Ward		Position Held
Date	To:	From:
Months in Post		
(3rd) Referee's Name From Current Position or Most Recent Employment		
Referee's Position		
Referees Contact Details Phone/ Fax / Email		

Please continue your experience and employment on a separate Curriculum Vitae

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Please place a tick in the box that most accurately describes your level of expertise for the skills listed.

Levels of proficiency:

1. Performs well with, minimum of 1 years of current experience and can perform without supervision
2. Limited experience less than 1 year and would require some assistance
3. No experience

Skills	<u>1</u>	<u>2</u>	<u>3</u>	<u>Comments</u>
<u>CARDIOLOGY</u>				
Pre & post coronary angiography				
Pre & post coronary angioplasty				
Unstable angina				
Cardiac failure				
<u>CARDIAC SURGERY</u>				
Pre & post cardiac surgery				
Coronary artery bypass grafts				
<u>ACUTE MEDICINE</u>				
Respiratory				
Gastroenterology				
Dermatology				
Neurology				
Insulin dependant diabetes				
<u>ACUTE SURGERY</u>				
General				
Gynaecology				
Urology				
Vascular				
Plastics				
Paediatric ENT				
<u>ORTHOPAEDIC</u>				
Pre & post total knee replacement				
Pre & post total hip replacement				
<u>ONCOLOGY</u>				
Patients receiving radiotherapy				
Patients receiving chemotherapy				
Neutropenic isolation				
<u>NEUROSURGERY</u>				
Lumbar discectomy				
Cervical discectomy				
<u>DAY SURGERY</u>				
Pre & post care				
General surgery				
Angiography				
Dermatology				
Endoscopy				

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<u>PHARMACOLOGY</u>				
Total parenteral nutrition				
Epidural analgesia				
Patient controlled analgesia				
Blood transfusion/platelets				
I.V. fluids/piggybacks				
Nasogastric medication				
Intradermal injections				
Sub-cutaneous injections				
<u>PAEDIATRIC / CHILDREN</u>				
Care of N.I.P.I ventilator				
Care of tracheostomy				
Administration of paediatric medication dosages				
Competency in completing paediatric care plans				
Competency in pain assessment/management				
<u>TYPE OF NURSING</u>				
Team nursing				
Primary nursing				
<u>COMPUTER EXPERIENCE</u>				
Laboratory				
Nursing documentation				
<u>ADDITIONAL EXPERIENCE</u>				

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Personal Pay Details

Please fill in the following information carefully and return it with your application form

Name	
Address	
Date of Birth	
Contact Phone Number	
Email Address (for payslips)	
An Bord Altranais PIN	
PPS Number	
Bank Name	
Bank Address	
Bank Sort Code (6 numbers)	
Bank Account Number (8 numbers)	
Do you have a P45 from your previous employers?	

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Health Declaration

I declare that I understand, accept and confirm the entitlement of Cpl Healthcare incorporating Servisource Healthcare (the agency) to reject my application or terminate my employment (in the event of a contract of employment having been entered into) where I have omitted to furnish the Agency with any information relevant to this health assessment or where I have made any false statement or misrepresentation relevant to this health assessment.

Please answer YES or NO and if YES, please give details in the space provided.

		Yes	No	Details
1	Do you have, or have you ever had, any medical conditions or surgery in the past 5 years?			
2	Are you at present attending a doctor for medical care, taking any medication or on a waiting list for hospital assessment or treatment?			
3	Have you ever suffered a work related illness, or given up work due to ill health?			
4	Do you have impairment / disability (physical or mental) or specific learning disability which may affect your ability to work?			
5	Have you ever suffered from tuberculosis (TB)? Within the past 12 months			
	Has any family member or close contact been treated for TB?			
	Have you had a cough for more than 3 weeks?			
	Have you coughed up blood?			
	Have you had any unexplained weight loss?			
	Have you suffered from night sweats or fever?			
6	Have you ever had any kind of back, joint or muscle problem?			
7	Have you ever had: Dermatitis, Eczema, Psoriasis or any other skin condition?			
8	Have you ever had any mental illness which might affect your ability to work? (including anxiety, depression, self-harm, eating disorders, psychological or emotional problems)			
9	Have you ever had a drug or alcohol problem?			

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10	Do you have any difficulty with your eyesight (including colour blindness)?			
11	Do you have difficulty with your ears or hearing?			
12	Have you ever suffered from any of the following; loss of consciousness including fainting attacks, blackouts, dizziness, epilepsy?			
13	Have you ever suffered from any of the following; heart disease or circulatory problem; including high blood pressure, varicose veins			
14	Have you ever suffered with chest or lung problems; Asthma, Bronchitis?			
15	Have you any allergies; including allergies to drugs, food or latex?			
16	Have you ever received treatment for bowel or gastric problems?			
17	Have you ever suffered a disorder of the bladder or kidneys?			
18	Do you have any other medical condition not previously mentioned in questions 1 – 17 above?			

Previous Sickness Absence – time lost from work due to illness over last 2 years.

Length of absence	Reason for absence

GP Name	
GP Address	
GP Telephone	

Signed: _____

Print Name: _____

Date: _____

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Declaration

I agree to the following:

- I confirm that the information given on this form application form is complete and correct.
- I agree to Cpl Healthcare incorporating Servisource Healthcare terms and conditions of employment.
- Cpl Healthcare incorporating Servisource Healthcare is authorised to acquire any information sought concerning the application and regarding my work character or skills and that this information may be forwarded to potential employers.
- I agree to treat as confidential any information received concerning the business of Cpl Healthcare incorporating Servisource Healthcare or its clients.
- Cpl Healthcare incorporating Servisource Healthcare will not be liable for professional negligence, errors, omissions, or accidents whilst you are under the hirer's custody or control.

Signed: _____

Print Name: _____

Date: _____

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Working Time Regulations

The European Union has laid down guidelines for all workers governing the length of the maximum working week, which it is deemed safe to work. The current limit is a maximum average net weekly working time of 48 hours per week over a period of 16 weeks.

Copy of Working Time Regulation Act is available to you upon request.

I confirm that I have read and understand the information regarding the working time regulations and it is my responsibility to adhere to same.

Signed: _____

Print Name: _____

Date: _____

Hand washing technique declaration

Hand washing is the single most important procedure in the implementation of infection control.

It is essential to wash hands frequently and correctly.

All employees of Cpl Healthcare incorporating Servisource Healthcare are obliged to follow hand washing procedures whilst on duty, according to attached hand washing technique.

I confirm I have and read understand the information regarding hand washing procedures and will adhere to this technique whilst on duty for Cpl Healthcare incorporating Servisource Healthcare.

Signed: _____

Print Name: _____

Date: _____

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Criminal Declaration

Please note this Criminal Declaration must be witnessed by either:

- *Commissioner of Oath*
- *Solicitor*
- *Garda Siochana*

I, (NAME) _____

of (ADDRESS) _____

HEREBY DECLARE that:

I have never been arrested for or convicted of any offence or crime (other than an offence under road traffic legislation), either in Ireland or in any other state;

I have never been the subject of a pardon or amnesty or other similar legal action in respect of any offence or crime (other than an offence under road traffic legislation for which a penalty of imprisonment is not enforceable);

I have never unlawfully distributed or sold a controlled substance (drug);

I am not currently nor have I ever been under investigation by the Garda Siochana police force of any state in relation to the commission of a crime (other than an offence under road traffic legislation for which a penalty of imprisonment is not enforceable);

I am not currently nor have I ever been the subject of disciplinary action by any professional or statutory body with responsibility for regulation of the nursing or medical professions.

I hereby authorise each of the Dublin Academic Teaching Hospitals and/or its relevant health board to make enquiries, for the purpose of verifying any part of this declaration, with An Garda Siochana and/or with the regulatory body of the nursing or medical professions of any state. This data will be processed by the Hospital and the Agency in accordance with the Data Protection Acts, 1988 and 2003.

Signed _____ Date _____

Witnessed by: _____ Date _____

Official Stamp:

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VACCINATION / IMMUNINE STATUS HISTORY

To be completed and stamped by an Occupational Health Professional / General Practitioner.

Name: _____ Date of Birth: _____

The above person has the following vaccinations carried out.

Hepatitis B 1ST Date: _____ 2nd Date _____ 3rd Date: _____

Hepatitis B Titre Date: _____ Result: _____ mIU/ml

Hepatitis B Booster Date: _____

Hepatitis B Titre Date: _____ Result: _____ mIU/ml

Measles (Serology) Date: _____ Result: _____

Mumps (Serology) Date: _____ Result: _____

Rubella (Serology) Date: _____ Result: _____

Varicella (Serology) Date: _____ Result: _____

Hepatitis C (Serology) Date: _____ Result: _____

Mantoux Test 2TU Date: _____ Result: _____

Mantoux Test 10TU Date: _____ Result: _____

BCG Scar Check Date: _____ Location: _____

Completed by:

Signature: _____

Title: _____

OFFICIAL STAMP:

Facility: _____

Date Completed: _____



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Exposure Prone Procedures (EPP)

Do you undertake Exposure Prone Procedures: **Yes** **No**

If **YES** the occupational health checks below must be completed out by a Medical Practitioner.

Tests must be carried out on identified validated samples (IVS). Only results from an Irish or UK occupational health service that has confirmed the identity of the person by checking appropriate photographic ID e.g. passport, driving licence or a photographic ID card will be accepted. For International recruitment, please refer to International recruitment documentation.

Specific requirements of Health Care Workers performing Exposure Prone Procedures

Hepatitis B antibody (Anti-HBs)	Date checked: _____	Result: _____
Hepatitis B core antibody (Anti-HBc)	Date checked: _____	Result: _____
Hepatitis B surface antigen (HBsAG)	Date checked: _____	Result: _____
Hepatitis Be antigen (HBeAG) <i>(If Hepatitis B surface antigen test is positive)</i>	Date checked: _____	Result: _____
Hepatitis B viral load <i>(If Hepatitis B surface antigen / Hepatitis Be antigen test is positive)</i>	Date checked: _____	Result: _____
Hepatitis C antibody	Date checked: _____	Result: _____
Hepatitis C virus RNA <i>(If Hepatitis C antibody test is positive)</i>	Date checked: _____	Result: _____

Completed by:

Signature: _____

Title: _____

OFFICIAL STAMP:

Facility: _____

Date Completed: _____

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INFORMATION

Application Requirements

As per An Bord Altranais recommendations, Cpl Healthcare incorporating Servisource Healthcare requires that nurses who have not worked within a nursing role in 3 years complete an An Bord Altranais approved 'Back to Nursing' course before applications can be processed.

Garda Vetting Form

Cpl Healthcare incorporating Servisource Healthcare seek Garda Vetting for all applicants. This is an important document that needs to be completed as instructed below.

We need you to complete and return the form to us at **2nd Floor 49 St Stephens Green Dublin 2**

Please ensure when completing the Garda form that you have all the following details:

- **Full name** (and any previous names)
- **Addresses** – if you are unsure of the full address then please enter in any of the address information you do know e.g.: if you do not know the number of the house that you lived in but you know the street name and town then please state the address with the information you know. Please list all addresses since birth including any from overseas
- Please ensure that, on the 2nd page, under your signature you complete your **FULL NAME** in **BLOCK CAPITALS**

Please write legibly in black pen and return the completed form with €10 cheque/postal order made payable to Cpl Healthcare.

Upon successful completion of this application form your Cpl Healthcare incorporating Servisource Healthcare Recruitment Consultant will arrange to meet you.

Once again thank you for taking the time to complete this application form and we look forward to working with you in the near future.

Kind regards,





Cpl Healthcare Nurse Application Form

**Elaine Higgins
Manager**