

Registration Pack for Carers

Welcome to First Option Healthcare, we look forward to working with you! To complete your registration with us, you need to complete the following stages of registration:

Stage 1



Registration Form
CV
Passport or Right to Work in the UK

Stage 2



DBS Certificate (We must be able to perform a check on the Online Update Service).
Mandatory Training - Completed within the past 12 months

Stage 3



NI Card/Letter.
Two Proofs of Address (Colour copy of drivers licence/
Council Tax letter/ Bank Statement/ Utility Bill).

Stage 4



Photo (for ID Badge)
Qualifications
Immunisations

Once you have completed your registration, a welcome pack will be sent out to you with instructions on how to use our electronic timesheets and an ID Badge. You can send in your documents via the following methods:

WhatsApp: 07540 913 804
E-mail: registrations@firstoptionhc.com
Post: Use address above.

If you have any queries, please do not hesitate to contact us on 0333 577 0305 - Option 3.

Kind Regards,

First Option Compliance & Registration Team

Please fill each box in as required. If you are unable to provide the information, please leave the field blank.

PERSONAL INFORMATION			
TITLE		FIRST NAME:	UNIFORM SIZE:
SURNAME			
ADDRESS:			
ADDRESS LINE 2:		CITY:	
POSTCODE:		MOBILE:	
HOME TEL:		EMAIL:	
DOB:		NATIONALITY:	

NEXT OF KIN PLEASE PROVIDE CONTACT DETAILS OF AT LEAST ONE PERSON WE CAN CONTACT IN CASE OF EMERGENCY			
NAME:			
RELATIONSHIP:			
ADDRESS:			
ADDRESS LINE 2:		CITY:	POSTCODE:
HOME NUMBER	MOBILE NUMBER	EMAIL ADDRESS	

YOUR TRAVEL & WORK PREFERENCES	
Are you a driver?	How far are you willing to travel?
Would you relocate for work (with accomodation)?	
Are you currently in regular work?	
Which Shift Patterns do you prefer? (Any/Days/Nights/Weekends)	

YOUR CLINICAL EXPERIENCE			
How many years/months of healthcare experience do you have?			
Please tick boxes below to indicate areas that you have experience in			
Live-in Care	<input type="checkbox"/>	Domiciliary/Homecare	<input type="checkbox"/>
Complex Care	<input type="checkbox"/>	Nursing Home	<input type="checkbox"/>
		Hospitals	<input type="checkbox"/>
		Other (please specify)	

Complex Care - Please tick any skill that you've had training for or have experience in			
Tracheostomy Care	<input type="checkbox"/>	PEG- Feeding	<input type="checkbox"/>
Medication Administration	<input type="checkbox"/>	Cough Assist	<input type="checkbox"/>
Nebuliser Administration	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
NG Tube Management & Care	<input type="checkbox"/>	Invasive Ventilation	<input type="checkbox"/>
NJ Tube Management & Care	<input type="checkbox"/>	Non-Invasive Ventilation	<input type="checkbox"/>
IV Therapy	<input type="checkbox"/>	Female Catheter Care	<input type="checkbox"/>
Bowel Management	<input type="checkbox"/>	Colostomy	<input type="checkbox"/>
Other (Please Specify)		Oral Suctioning	<input type="checkbox"/>
		Invasive Suctioning	<input type="checkbox"/>
		Seizure Management	<input type="checkbox"/>
		Dysphasia	<input type="checkbox"/>
		Oxygen Therapy	<input type="checkbox"/>
		Male Catheter Care	<input type="checkbox"/>
		Ileostomy	<input type="checkbox"/>

PROFESSIONAL CONDUCT			
Has there been any proceedings of medical negligence or professional misconduct against you?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
If Yes, please supply details (Use an extra sheet of paper if you require more space):			
REHABILITATION OF OFFENDERS ACT			
Because of the nature of the work for which you are applying, Section 4(2), and further orders made by the Secretary of State under the provision of this section of the Rehabilitation of Offenders Act (1974) (Exceptions) Order 1975 applies, applicants are therefore required to give information about convictions which for other purposes are "spent" under the provisions of the Act. Any information given will be completely confidential and will be considered only in relation for positions to which the order applies			
Have you at any time been convicted of an offence?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
If Yes, please supply details (Use an extra sheet of paper if you require more space):			
Signed:		Date:	

REFERENCE DETAILS	
<ul style="list-style-type: none"> Please supply the names and addresses for at least 3 referees One must be from your present or most recent employer and <u>must</u> be a senior grade to yourself The references must cover a period of 5 years in total 	
CLINICAL REFERENCE 1	
Name:	
Position:	
Address:	
Daytime Phone:	Postcode:
Email Address:	
What is your professional relationship with this person?	
From:	To:
REFERENCE 2	
Name:	
Position:	
Address:	
Daytime Phone:	Postcode:
Email Address:	
What is your relationship with this person?	
From:	To:
REFERENCE 3	
Name:	
Position:	
Address:	
Daytime Phone:	Postcode:
Email Address:	
What is your relationship with this person?	
From:	To:

DECLARATIONS

1. Hepatitis B

- I have been advised at registration of the importance of having the Hepatitis B vaccine.
- I acknowledge that I have been/am being vaccinated against Hepatitis B and will continue to maintain my immunity.
- I accept responsibility for my decision and I will ensure that I take all precautions to avoid contracting the illness and avoid accepting work within environments which are hazardous.

2. Terms & Conditions

- I confirm that the information given in this application is, to the best of my knowledge, true.
- I am permitted to work in the UK.
- I understand that my registration is subject to the receipt of at least two satisfactory references and an enhanced disclosure from the Disclosure and Barring Service (DBS).
- I undertake to inform First Option Healthcare should I be convicted of an offence in the future.
- I undertake to inform First Option Healthcare immediately if I am engaged through their introduction, including the offer of permanent employment following a temporary assignment.
- I agree to respect the confidentiality of patients and any other information I may have access to, at all times.
- I am clear that First Option Healthcare cannot guarantee assignments and that they have no responsibility to pay for hours not worked no matter the situation.
- I have read, understood and agree to the terms & conditions of work for temporary nurses, of which I have been given a copy or have downloaded from www.firstoptionhc.com.

3. Working Time Regulations

- For the purpose of the Working Time Regulations 1998 (as amended), I consent to work in excess of an average of 48 hours per week.
- I understand that I may withdraw this consent by giving First Option Healthcare not less than three months' notice.
- I understand that my registration with any company can be terminated at any time following unsatisfactory work reports or complaints.

4. Bank Details

- I confirm that the bank details that I have given on this form are complete and correct and that any incorrect or incomplete details can result in a delay of any payments.

5. Data Protection & Permissions

- I agree that First Option Healthcare retains the right to hold this application and any other data required to process it and to pass on to any authorised third party for the purposes of audit and work placements.
- I agree that First Option Healthcare can retain these details for as long as reasonably necessary in accordance with the Data Protection Act.

6. Disclosure and Barring Update Service Checks

- I agree that First Option Healthcare can access the DBS update service portal to check for any changes to my DBS clearances as and when necessary.

7. Handbook Declaration

- I have received (or downloaded) the company handbook and have understood and will comply with it at all times. I am aware that any amendments or new versions will be available on.

8. Responsibility of Compliance

- I understand that I am responsible for ensuring that my personal compliance such as my NMC registration, re-validation, DBS update service and mandatory annual training are kept up to date. If any of my compliance items lapse, it may cause the suspension and/or termination of my placement and I will be unable to work until my compliance items are updated.

Signed

Date