



**GENERAL PERSONAL DETAILS:**

TITLE: \_\_\_\_\_  
 SURNAME: \_\_\_\_\_  
 FORENAME(S): \_\_\_\_\_  
 MARITAL STATUS: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 GENDER: \_\_\_\_\_  
 ADDRESS 1: \_\_\_\_\_  
 ADDRESS 2: \_\_\_\_\_  
 CITY: \_\_\_\_\_  
 COUNTY: \_\_\_\_\_  
 POST CODE: \_\_\_\_\_  
 COUNTRY: \_\_\_\_\_  
 TEL1: \_\_\_\_\_  
 TEL2: \_\_\_\_\_  
 OTHER No: \_\_\_\_\_  
 FAX: \_\_\_\_\_  
 MOBILE: \_\_\_\_\_  
 E-MAIL1: \_\_\_\_\_  
 E-MAIL2: \_\_\_\_\_

**NEXT OF KIN:**

TITLE: \_\_\_\_\_  
 SURNAME: \_\_\_\_\_  
 FORENAME(S): \_\_\_\_\_  
 RELATIONSHIP: \_\_\_\_\_  
 ADDRESS1: \_\_\_\_\_  
 ADDRESS2: \_\_\_\_\_  
 CITY: \_\_\_\_\_  
 COUNTY: \_\_\_\_\_  
 POST CODE: \_\_\_\_\_  
 TEL1: \_\_\_\_\_  
 TEL2: \_\_\_\_\_  
 MOBILE: \_\_\_\_\_  
 FAX: \_\_\_\_\_  
 E-MAIL1: \_\_\_\_\_  
 E-MAIL2: \_\_\_\_\_  
 GP Name: \_\_\_\_\_  
 GP Address: \_\_\_\_\_  
 GP Telephone: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US:**

PRINTED ADVERT	<input type="checkbox"/>	ONLINE REGISTRATION	<input type="checkbox"/>
WEB ADVERT	<input type="checkbox"/>	AGENT	<input type="checkbox"/>
WORD OF MOUTH	<input type="checkbox"/>	OTHERS	<input type="checkbox"/>

**IMMIGRATION STATUS**

Nationality: \_\_\_\_\_ Type of the current visa: \_\_\_\_\_  
 Proof provided: \_\_\_\_\_ Valid from \_\_\_\_\_ To \_\_\_\_\_

**TYPE OF ENGAGEMENT**

Please tick as appropriate and provide information accordingly:

PAYE <input type="checkbox"/>	Please provide: National Insurance Number, Bank Account Number, Sort Code
Self Employed <input type="checkbox"/>	
Limited Company <input type="checkbox"/>	Please provide: Company Name, Company Registration Number, Date of Registration, Bank Account Number, Sort Code



**ABOUT PROFESSION**

<b><u>HOSPITAL DOCTORS;</u></b> <i>Please specify your preferences bellow:</i>		
GRADE	SPECIALITY	SUB-SPECIALITY

<b><u>GENERAL PRACTITIONERS;</u></b> <i>Please tick as appropriate:</i>			
SPECIALITY	<i>tick</i>	COMPUTING SYSTEM	<i>tick</i>
DAY SURGERY		EMIS	
OOH SERVICE		VISION	
HMPS		ADASTRA	
FME		SYSTEM 1	
MoD		TOREX	
IRC (Immigration Removal Centres)		OTHER	

<b><u>PHARMACY</u></b>		
<i>Please tick and specify as appropriate</i>		
Qualified and Registered <b>Pharmacist</b>		
<b>Technician</b> or <b>Dispenser</b>		
<b>Other</b> , please specify		

<b>PREFERENCES:</b>		
<b>Hospital</b> (Please specify dispensary or ward)		
<b>Community</b> (Please specify independent or Chain)		
<b>HMPS</b>		
<b>Other</b> (Please specify)		

<b><u>SPECIAL TRAINING;</u></b>
<i>Please specify if you have taken any special trainings and provide proof such as (MUR, CPPE, etc)</i>

<b><u>COMPUTING SYSTEMS;</u></b> <i>Please specify computing systems you are familiar with</i>



## DOCUMENTS CHECK LIST

<u>ORIGINAL COPIES MUST BE VERIFIED</u>	YES	NO	NOTES
UP TO DATE CV			
PROFESSIONAL BODY CERTIFICATE OF REGISTRATION			GMC, NMC OR RPSGB
PROOF OF SPECIALIST REGISTRATION			GP REGISTER OR THE SPECIALIST REGISTER
PROOF OF IMMIGRATION STATUS			
PHOTO ID (PASSPORT, ID CARD, DRIVING LICENSE)			
PROFESSIONAL INDEMNITY INSURANCE			
BASIC AND POSTGRADUATE QUALIFICATIONS			
CERTIFICATES OF GENERAL TRAININGS LIKE (MANUAL HANDLING, HEALTH AND SAFTY ETC.)			
<u>PROOF OF PROFESSIONAL SPECIALIST TRAININGS SUCH AS:</u>			
DRUG MISUSE			
ALS, APLS, CALS, etc.			
SECTION 12			
FAMILY PLANING			
OTHER, PLEASE SPECIFY			
<u>PROOF OF INCLUSION ON A UK MEDICAL PERFORMERS LIST:</u>			
ENGLAND			
SCOTLAND			
WALES			
OCCUPATIONAL HEALTH QUESTIONNAIRE AND DECLARATION			
<u>ORIGINAL PROOF OF THE FOLLOWING MUST BE VERIFIED:</u>			
HEPATITIS B			
HEPATITIS B SURFACE ANTIGEN ( <b>EPP ONLY</b> )			
HEPATITIS C ( <b>EPP ONLY</b> )			
RUBELLA			
VARICELLA			
BCG / TUBERCULOSIS			
MEASLES			
MUMPS			
HIV ( <b>EPP ONLY</b> )			

### STATE REGISTRATION WITH PROFESSIONAL BODY IN THE UK:

- GMC  
 NMC  
 RPSGB  
 HPC  
 OTHER

REGISTRATION NUMBER:

DATE OF REGISTRATION:

I undertake that I will inform Clinical Employment Services Limited / CES Locums of any changes to my registration status with the professional body also of any allegations, suspensions and any related issues.

I understand that Clinical Employment Services Limited / CES Locums will liaise and communicate with the professional body regarding any complaints about my professional conduct accrued during any work engagement through CES Locums.

### PROFESSIONAL INDEMNITY INSURANCE

Do you have Professional Indemnity Insurance?

- Yes  
 No

If the answer is yes, please provide details:

INSURAR:  
 MEMBERSHIP NUMBER:  
 ISSUE DATE:



**CRIMINAL RECORD**

Type of Criminal Record Clearance: CRB Disclosure:  Police Clearance

Reference of Clearance Certificate: \_\_\_\_\_ Date of Certificate \_\_\_\_\_

Carried by (Registered Body) \_\_\_\_\_

EXEMPTED QUESTION: Have you ever had a spent or unspent criminal conviction/s Yes  No   
If the answer is yes, please provide details on a separate sheet.

I hereby give my consent Clinical Employment Services Limited T/A CES Locums:

1. To carry out Criminal Record Check with the CRB on my behalf
2. Disclose my CRB information to Clients.

I understand that is my obligation to inform Clinical Employment Services Limited / CES Locums of any eventual changes to my Criminal Record Status immediately

**SIGNATURE**

**DATE**

**Statement on Working Time Regulations (WTR)**

The Working Time Regulations 1998 require Clinical Employment Services Limited / CES Locums to limit your average weekly working time to 48 hours unless you agree in writing that those limits shall not apply to you. In those circumstances you should complete the declaration set out below.

**I agree that I do not want the Working Time Regulations to apply to me**

Should I wish to terminate this agreement about the WTR, I shall give Clinical Employment Services Limited / CES Locums 4 weeks written notice.

**DECLARATION**

- I CONFIRM THAT I AM 18 YEARS OF AGE OR OVER.
- I ACKNOWLEDGE THAT NEITHER CES LOCUMS, NOR IT'S EMPLOYEES HOLD ANY RESPONSIBILITY OR LIABILITY WHATSOEVER FOR THE SERVICES I PROVIDE, NOR THE CONSEQUENCES OF THE PROVISION OF SUCH SERVICES, INCLUDING PERSONAL ACCIDENT, DAMAGE TO THE CLIENT'S PROPERTY etc.
- I DECLARE THAT ALL THE INFORMATION I HAVE GIVEN IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.
- I HAVE READ AND AGREE TO ABIDE FULLY BY THE TERMS AND CONDITIONS OF WORKERS OF CLICAL EMPLOYMENT SERVICES LIMITED T/A CES LOCUMS.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_