

Thank you for taking the time to register with MediQuest, if there any issues concerning completing this registration form, please contact us on 0207-183-9191

REGISTRATION FORM

Personal Details

Surname:	Forenames:	Title:
GMC Number:	Date of Birth:	Age:
Mobile:	Work Tel:	Bleep:
Email Address:	Home Tel:	
Address:		
Postcode:		

Next of Kin

Name:	Relationship:	Tel Day:
Address		Tel Evening:

Locum Requirements

Availability?	From:	To:
Grades and specialties are you qualified to cover?		
Do you have any preferred locations?		
Are you interested in Long Term <input type="checkbox"/> Short Term <input type="checkbox"/> Ad Hoc <input type="checkbox"/>		Do you own a car? Yes <input type="checkbox"/> No <input type="checkbox"/>

Right to Work in the UK

Are you a British Citizen / EC National? Yes <input type="checkbox"/> No <input type="checkbox"/>
If no, what is your visa status? (please enclose a copy of your entry stamp, visa or permit)

Referees

Please supply details of two clinical referees if not on your CV. One must be from your present or most recent employer. Please note we will apply for references from the below persons and disclose copies to our clients for the purpose of finding you a locum post.		
1. Name:	Position:	Tel:
Work address:		Fax:
2. Name:	Position:	Tel:
Work address:		Fax:

Professional Membership

Please confirm you are aware of the GMC's performance monitoring process and have made formal arrangements to be appraised regularly by an appropriately trained medical practitioner entered in the Specialist Register? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name and contact details of a registered medical practitioner who has agreed to act as your appraiser:		
Date of appraisal:	Date of next appraisal:	
Professional Indemnity: We recommend that you take membership of a Medical Defence Organisation. If you are already a member please provide details of your membership. Please forward a copy with your application.		
Defence Body:	Policy Number:	Expiry Date:

Professional Development

Have you ever had training in the following?

Fire and Safety	YES/NO	DATE:
Health and Safety	YES/NO	DATE:
Moving and handling	YES/NO	DATE:
COSHH	YES/NO	DATE:
RIDDOR	YES/NO	DATE:
Infection Control	YES/NO	DATE:
Complaints Handling	YES/NO	DATE:
Risk Incident Reporting	YES/NO	DATE:

Where you have answered yes, please give dates of training and provide copies of your certificates.

DECLARATION

I confirm that I have read this document fully and that all the information given to serving The Nation Locums Limited is correct to the best of my knowledge. I am not aware of any condition, medical or otherwise, which would limit or affect my employment or performance. I acknowledge that I have been given a copy of the current terms and conditions of service issued by Serving The Nation Locums Ltd, and that I have read those terms and agree to abide by them. I can confirm that I am happy to agree with the Working Time Regulation notes as detailed within this document. I understand that Serving The Nation Locums Ltd will process my personal data in accordance with the Data Protection act for the purposes of seeking employment opportunities. I authorize disclosure of my personal data to such third parties as Serving The Nation Locums Ltd sees appropriate

Name:..... D.O.B..... Signature:..... Date:.....

Fitness to Practice

Declaration Regarding Doctors' Fitness to Practice, Proceedings by a Licensing /Regulatory Body & Relating to Criminal Investigations in the UK or Overseas. Statement of criminal convictions & Police Check Clearance

Because of the nature of the work for which you are applying, 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 (Exemptions Order 1975). Applicants are, therefore, not entitled to withhold any information about convictions, which for other purposes are, then 'spent' under provision of the Act, and in the event of employment, failure to disclose such convictions could result in disciplinary action including dismissal being taken by the Health Authority. You are therefore required to declare all criminal convictions or cautions. Any information given will be completely confidential and will be considered only in relation to an application for positions to which the order applies and will not debar from appointment unless the selection panel considers that it renders you unsuitable for appointment. In reaching such a decision we will consider the nature of the conviction, action, how long ago it took place and any other factors that may be relevant. Failure to disclose a criminal offence, having been bound over or cautioned or that you are currently the subject of criminal proceedings which might lead to a conviction, an order binding you over or a caution, or fitness to practice proceedings undertaken by an appropriate licensing or regulatory body, may disqualify you from appointment, or result in summary dismissal/disciplinary action and referral to the General Medical Council or General Dental Council for consideration if such discrepancy came to light.

- Have you been convicted of a criminal offence, been bound over or cautioned or are you 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? **YES/NO**
If YES, please provide details of the criminal offence; order binding you over or caution or details of any current proceedings, which might lead to a conviction, an order binding you over or caution, including approximate date, the offence, the authority and the country, which dealt with the offence.

Note: Applicants for posts in the NHS are exempt from the Rehabilitation of Offenders Act 1974. You are required to declare prosecutions, including those considered "spent" under this Act.

- Have you been or are you currently subject to any fitness to practice proceedings by an appropriate licensing or regulatory body in the UK or any other country. **YES/NO**
If YES, please provide details of the nature of the proceedings undertaken, or contemplated, including approximate date of proceedings, country where the proceedings were undertaken and the name and address of the licensing or regulatory body concerned.

Have you ever been suspend from duty with any organisation or with the GMC **YES/ NO**

Please sign below and return this form to us.

I (print name) hereby declare that the information given here is correct.

Signed: Date.....

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Occupational Health Screening History

Have you worked in the NHS in the past 12 months? Yes No

Date of most recent immunisation screening:

Name of the trust or hospital that gave you most recent screening:

Medical Questionnaire

The following information must be completed in full; this may determine whether we can find you a locum position.

Please complete the following questionnaire:			Do you or have ever suffered from the following:		
Any conditions which restrict your ability to work	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Skin symptoms, disorders or diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you require any adjustments to undertake work	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Recurrent sore throat (including MRSA infections)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you any known allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stress related symptoms, disorders or diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you suffering from vomiting, diarrhea or rash	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Imunno-deficiency symptoms (including HIV)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have speech, hearing or visual difficulties	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Overseas travel symptoms, disorders or diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had problems with drug/alcohol misuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Genitourinary symptoms, disorders or diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you suffered from any mental illness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthma, bronchitis or any other chest illness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Under treatment or on a waiting list for treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Endocrine symptoms, disorders or diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had any major illnesses or operations	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cardiovascular symptoms, disorders or diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you any disabilities or registered disabled	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Haematological symptoms, disorders or diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had long term absence due to sickness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bone or joint symptoms, disorders or diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you pregnant	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Gastrointestinal symptoms, disorders or diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you currently taking any medication	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Psychiatric symptoms, disorders or diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any aspect of your medical history we should know	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Neurological symptoms, disorders or diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Additional Information

Please use this space to provide any additional information that may be relevant. If you have answered yes to any of the above medical questions please provide details including dates, diagnosis, and whether any time was taken off work for treatment. Please continue on an additional sheet if required.

Immunisation Details Required

We require copies of the pathology reports for: (If you do not have all the required documentation please advise us as we can assist)

1. Tuberculosis PLEASE SEND	Have you had a BCG (TB) vaccination? Yes <input type="checkbox"/> No <input type="checkbox"/> Date:	All applicants must arrange to have the attached TB evidence form completed. (unless TB serology attached)
	Have you ever been treated for TB? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Have you had a tuberculin skin test? Yes <input type="checkbox"/> No <input type="checkbox"/>	Year: Result:
	Have you visited any high TB or HIV prevalence countries in the last 3 years or left the UK in the last 3 months? Yes <input type="checkbox"/> No <input type="checkbox"/>	Country: Date: Duration of stay:
	In the past 12 months, have you had an unexplained cough for more than 3 weeks, fever or weight loss? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	In the last 2 years, have you had a Chest x-ray? Yes <input type="checkbox"/> No <input type="checkbox"/>	If 'Yes', please provide a copy of the result
2. Varicella PLEASE SEND	Have you had chickenpox or shingles? Yes <input type="checkbox"/> No <input type="checkbox"/>	If 'No', please provide a copy of evidence on immune status
3. Hepatitis B PLEASE SEND	Please attach evidence of your Hepatitis B immunity status	All clinicians must supply evidence of HbsAB. If the result is <10iu, further testing may be needed to exclude infection.
4. Measles PLEASE SEND	Hospitals are now insisting on seeing evidence of immunity to MMR	We require evidence of immunity. Please send serology.
5. Mumps PLEASE SEND	Hospitals are now insisting on seeing evidence of immunity to MMR	We require evidence of immunity. Please send serology.
6. Rubella PLEASE SEND	Hospitals are now insisting on seeing evidence of immunity to MMR	We require evidence of immunity. Please send serology.
For doctors undertaking exposure prone procedures (EPPs) please address items 7 & 8 below. Exposure prone procedures are those where there is a risk that injury to the doctor could result in their blood contaminating a patients open tissues. Exposure prone procedures occur mainly in surgery.		
7. Hepatitis B&C	Please attach evidence of Hep B and C serology (doctors undertaking EPPs)	We require a negative test for Hep B and C (EPPs only)
8. HIV	Please attach evidence of HIV screening (doctors undertaking EPPs)	We require a negative test for HIV (EPPs only)
Please not blood test results for EPPs must be taken on an Identity Validated Sample.		

Declaration

I hereby certify that I am fit to Practice and that the answers to the above question are true and complete to the best of my knowledge and belief. I understand that making false statements or failure to declare health problem could lead to dismissal.

I acknowledge that I have been given the current terms and conditions of service and Staff Handbook issued by Mediquest Ltd, and that I have read and understood and agree to abide by them. I can confirm that I am happy to agree with the Working Time Regulation notes as detailed with this document. I understand that Mediquest Ltd will process my personal data in accordance with the Data Protection act for the purposes of seeking employment opportunities. I authorise disclosure of my personal data to such third parties as Mediquest Ltd.

Name: Signature:.....

D.O.B. Date:

BCG Scar Declaration Form

The Purpose of this form is to provide information in relation to TB protection to allow evaluation of the individual's fitness for work as a clinician within the NHS.

Section to be completed by candidate

Surname:	Forenames:
Grade and Speciality:	Date of Birth:
Photographic ID Verified? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Section to be completed by Health Care Professional

Surname:	Forenames:
Tel:	GMC or NMC PIN Number:
Address:	
Postcode:	

Confirmation of competence

Individuals viewing BCG scars must be trained and competent to do so	
I confirm that I am:	
An Occupational Health nurse skilled in viewing BCG scars	<input type="checkbox"/> Please tick
An Occupational Medicine Physician	<input type="checkbox"/> Please tick
A Physician who is competent to view TB scars	<input type="checkbox"/> Please tick
A nurse who has been deemed competent to view BCG scars	<input type="checkbox"/> Please tick

Screening Result

Please examine the skin at the distal insertion of the deltoid, and look for a scar.	
Is there a scar on the skin over the deltoid, in a location consistent with a BCG vaccination?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Which side?	Right <input type="checkbox"/> Left <input type="checkbox"/>

Declaration

I hereby certify that I am competent in the admission and reading of mantoux skin testing and BCG Vaccination Scars.

Name: _____	Occupational Health Department Stamp
Date: _____	
Signature: _____	
Qualification/Designation: _____	
<small>Note, a stamp is required for this form to be valid</small>	