



**Hallam Medical Limited**  
19 Neepsend Triangle Business Centre  
1 Burton Road  
Sheffield  
S3 8BW

Tel: 0844 335 0395  
Fax: 0114 272 8539  
E-mail: [recruitment@hallammedical.com](mailto:recruitment@hallammedical.com)  
Web: [www.hallammedical.com](http://www.hallammedical.com)

**Contact Details:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Postcode: \_\_\_\_\_ N.I Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Daytime Telephone: \_\_\_\_\_ Evening Telephone: \_\_\_\_\_

Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Next Of Kin: \_\_\_\_\_

Contact Number in case of emergency: \_\_\_\_\_

**Professional Details:**

GMC Number: \_\_\_\_\_ Date of Reg: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Vocational Certification:**

JCPTGP	<input type="checkbox"/>	Number: _____	Date of Issue: ____ / ____ / ____
PMETB	<input type="checkbox"/>	Number: _____	Date of Issue: ____ / ____ / ____
Acquired Rights	<input type="checkbox"/>	Number: _____	Date of Issue: ____ / ____ / ____
Exempt	<input type="checkbox"/>	Number: _____	Date of Issue: ____ / ____ / ____
Other	<input type="checkbox"/>	Number: _____	Date of Issue: ____ / ____ / ____

Details (If other): \_\_\_\_\_

**PCT Performers List Details:**

PCT where registered: \_\_\_\_\_ Status: \_\_\_\_\_

Date of last appraisal: \_\_\_\_\_

**Professional Indemnity:**

Indemnifying Body: \_\_\_\_\_ Membership Number \_\_\_\_\_

Expiry: \_\_\_\_\_



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**Qualifications:**

Qualifying Degree: \_\_\_\_\_ Date of Award: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Institution: \_\_\_\_\_

**Other Professional Qualifications:** (eg, MRCGP, DRCOG, DFFP etc)

Name : \_\_\_\_\_ Date of Award: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Institution: \_\_\_\_\_

Name : \_\_\_\_\_ Date of Award: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Institution: \_\_\_\_\_

Name : \_\_\_\_\_ Date of Award: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Institution: \_\_\_\_\_

Name : \_\_\_\_\_ Date of Award: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Institution: \_\_\_\_\_

**BLS Certification:** \_\_\_\_\_ Date of Award: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Institution: \_\_\_\_\_

Present Role in Employment: \_\_\_\_\_

Present Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have a current enhanced CRB check:      Y     N:

Date of CRB check: \_\_\_\_ / \_\_\_\_ / \_\_\_\_    Disclosure Number: \_\_\_\_\_



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**IT Systems:**

Do you use Medical Information Systems (EMIS, Vision etc)? Y  N:

(Please circle as apt, 1 being basic 5 being Expert)

Name of System: \_\_\_\_\_

Proficiency: \_\_\_\_\_ 1/2/3/4/5

Name of System: \_\_\_\_\_

Proficiency: \_\_\_\_\_ 1/2/3/4/5

Name of System: \_\_\_\_\_

Proficiency: \_\_\_\_\_ 1/2/3/4/5

Name of System: \_\_\_\_\_

Proficiency: \_\_\_\_\_ 1/2/3/4/5

Do you have an NHS Smartcard: Y  N:

If yes please provide NHS Smartcard Number: \_\_\_\_\_

**Bank Details**

Name of Branch: \_\_\_\_\_

Sort Code: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Account Number: \_\_\_\_\_

Account Name: \_\_\_\_\_

Two Referees from Present employer.

1. \_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Tel: \_\_\_\_\_

Tel: \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_



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## Rehabilitation of Offenders

Because of the nature of General Practice, this position is exempt from the provisions of section 4.2 of the Rehabilitation of Offenders Act 1974 (Exemption Order 1975). You are therefore, not entitled to withhold information about convictions which for other purposes are 'spent' under the provisions of the Act.

In the event of engagement, any failure to disclose any convictions will result in immediate termination of the contract with further referral to the appropriate oversight bodies.

Any information given will be completely confidential and a criminal record will not necessarily be a bar to obtaining a position.

Have you ever been convicted of a criminal offence? Y  N.

Do you have any unspent convictions? Y  N

If yes please provide details: \_\_\_\_\_

Are you currently involved in any proceedings, which may lead to a criminal conviction? Y  N

If yes please provide details: \_\_\_\_\_

All of the above details are true and correct.

Signed:

Print Name:

Date:



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### **Document Checklist**

These are the documents we will need copies of during the process:

- Up to Date CV**
- GMC Certificate**
- Proof of Inclusion on a Performers List**
- Passport Photo**
- Proof of Indemnity**
- Proof of Identity (1 Photographic and 2 Proof of Address)**
- A copy of your Qualifications**
- Hep B Results**
- Existing CRB Disclosure**