



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
Web: www.hallammedical.com

Personal Details:

Form fields for personal details including Title, First Name, Middle Name(s), Last Name, Maiden Name, Gender, Date of Birth, Nationality, Mothers Maiden Name, Next of Kin and Relationship, Address, Town/City, County, Postcode, Email, Tel: Home, Tel: Mobile, How Did You Hear Of Us, and Next of Kin Contact Details.

Work Status (i.e. employed/unemployed permanent/temporary/bank)

National Insurance No

Driving Licence Yes No

Own Transport Yes No

Languages: Native, Second, Third, Fourth, Fifth, Sign



### Employment History

Please confirm your last 3 positions including your current employment. Please list using most recent first.

Employer:			
Address:			
Date started:		Date left:	
Job title:		FT / PT/ Bank	
Dept/Ward:		Band (if Applicable)	
Reason for leaving:			

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Address:			
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Reason for leaving:			

### Experience Profile

Please indicate the areas that you have experience in with a tick.

SPECIALISM	Less than 1 Year	1 to 2 Years	More Than 2 Years	SPECIALISM	Less than 1 Year	1 to 2 Years	More than 2 Years
A & E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Midwifery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acute Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neonatal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anaesthetic Trained	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ante Natal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nursing Homes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioural Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nurse Practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiothoracic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occupational Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of the Elderly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ODP/ODA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CCU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oncology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ophthalmology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Orthopaedics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cosmetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Out Patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CSSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Out Of Hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Day surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paediatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palliative Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
District Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phlebotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PICU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Practice Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fracture Experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prisons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GP Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU Med	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gynaecology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recovery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haematology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Visitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Residential Homes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Dependency Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SCBU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	School Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scrub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In Charge Duties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stoma Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intensive Care Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Telephone Triage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ITU Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Termination Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Theatre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tracheotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Assessment Unit / PAU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urgent Care Centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Minor Injury Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walk In Centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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**Qualifications & Training**

Professional Registration Body (NMC/HPC etc.): \_\_\_\_\_

Registration Number: \_\_\_\_\_

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

Are you currently suspended or under investigation with your professional registration body? (NMC/HPC etc.)

Yes  No  If yes please supply details... \_\_\_\_\_

Please note if the above changes you must make us aware as soon as possible.

Are you a non-medical Prescriber? Yes  No  Currently studying  If so due to complete \_\_\_\_\_

Do you have an NHS Smartcard? Yes  No  If yes please provide Smartcard Number: \_\_\_\_\_

Do you have a current Enhanced CRB check? Yes  No  Date of CRB check: \_\_\_\_\_

**Overview of Qualifications:**

(Please include course and date obtained)


**Bank Details**

Name of Bank: \_\_\_\_\_

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

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

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



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**References**

Hallam Medical requires 2 professional references from Line Managers, one of which must be your current Manager.

Name Of Referee: \_\_\_\_\_ Place Of Work \_\_\_\_\_  
 Position \_\_\_\_\_  
 Work Address: \_\_\_\_\_  
 Postcode: \_\_\_\_\_  
 Email: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_

Name Of Referee: \_\_\_\_\_ Place Of Work \_\_\_\_\_  
 Position \_\_\_\_\_  
 Work Address: \_\_\_\_\_  
 Postcode: \_\_\_\_\_  
 Email: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_

We require references for the past three years, so if the above references do not cover the past three years please continue on a separate sheet. Please also state any dates for previous references.

**Declaration**

I confirm that the information I have provided in support of this application is complete and true and understand that knowingly to make a false statement could be a criminal offence.

Signature: (Enter Surname if unable to sign) \_\_\_\_\_ Date: \_\_\_\_\_

Once completed please send the application form to the following address:-

Resourcing Consultant  
 Hallam Medical  
 19 Neepsend Triangle Business Centre  
 1 Burton Road  
 Sheffield  
 South Yorkshire  
 S3 8BW