



**Coben Healthcare registration form**

**Personal Details:**

Title:	First name	Surname
Other Name(s):		
Current Address:	National Insurance Number:	
	Date of Birth:	
	Mobile No:	
	Home Tel No:	
	Email Address:	
Post Code:		
Professional Registrations? GMC / NMC / HCPC / GPHC		
Reg Number:	Renewal Date:	

**Next of Kin details:**

Next of Kin Name:	Relationship to you:
Address:	
Postcode:	Telephone Number:

**Right to work information:**

I can confirm that I am entitled to work in the UK and will provide Coben Healthcare with all the relevant documents in accordance with the Asylum and Immigration Act (1997) - Please tick:

**Are you an EEA National/Citizen?**

Yes		No	
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**Do you have a current Biometric immigration document/permit issued by the Home Office?**

Yes		No / NA	
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**Employment History Guidance:**

Please confirm your CV is completely up to date with no more than a two week gap. Please include all permanent and agency work and each post must include days, months, years and locations of employment. All work history declared should be true and accurate and any gaps should be declared.

Please tick to confirm that your CV adheres to the above

**Professional Referees Guidance**

Your references are required to cover the last year of employment whether this be permanent or locum. You must have worked with your referee within the last 12 months, they also need to be clinically senior in order to be appropriate to provide a clinical reference. Character references will be accepted to add to your file from non-clinical staff who you have worked with, but this must be additional to 2 clinically senior references (if you are a GP, another GP will be accepted as a referee).

**Professional referees:**

Please give the names of professional refererees from your most recent engagements, which cover at least your last year of employment. Referees MUST be of a senior position to you

Name:	Name:
Position:	Position:
Organisation:	Organisation:
Postcode:	Postcode:
Tel Number:	Tel Number:
Email:	Email:
Period worked (MM/YYYY - MM/YYYY)	Period worked (MM/YYYY - MM/YYYY)

Name:	Name:
Position:	Position:
Organisation:	Organisation:
Postcode:	Postcode:
Tel Number:	Tel Number:
Email:	Email:
Period worked (MM/YYYY - MM/YYYY)	Period worked (MM/YYYY - MM/YYYY)

Do we have permission to request these references:      Yes         No  

**Working time regulations:**

The Working Time regulations 1998 ('The Regulation') require Coben Healthcare Limited to limit your average weekly working time unless you agree with Coben Healthcare that the limit shall not apply to your contract with us.

**The 48hr time limit will not apply to you**

Either party may terminate the agreement (so that the time limit will apply to you) by giving the person at Coben Healthcare to whom you usually report four weeks written notice. Unless it is terminated in this way, this agreement shall remain in force until your contract with us terminates.

Under regulation, Coben Healthcare must keep records relating to your working time. This is the case whether or not you reach an agreement with Coben Healthcare about waiving time limits.

Please sign the below to confirm you agree that this time limit on your working hours will not apply to your contract with Coben Healthcare and that your average working week may therefore exceed 48 hours in any given period

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Candidate Handbook**

Have you received, read and understood the Coben Healthcare Candidate Handbook?

Yes

**Appraisal and Revalidation**

Have you made formal arrangements to be appraised regularly by an appropriately trained medical practitioner within an approved NHS appraisal System?

YES         NO  

**Appraiser details:**

Name:	GMC number:	Email address:
Date of last appraisal:		
Copy of last appraisal provided?	Please tick:	
Revalidation date:		

**Fitness to Practice:**

Yes / No

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?

If yes, please provide details below of the nature of the proceedings undertaken, or contemplated, including approximate date of proceedings, country where proceedings were undertaken and the name of the licensing or regulatory body concerned.

Details of FTP:

**Disclosure and Barring Service:**

All public and private organisations request that an Enhanced Disclosure is obtained for all healthcare personnel which is acquired from the Disclosure Barring Service or Disclosure Scotland. Copies of Coben Healthcare policies on the Rehabilitation of Offenders Act are available on request

Please sign below to give Coben Healthcare permission to check DBS certificates portability status online

Full name: \_\_\_\_\_ Signature: \_\_\_\_\_

Occasionally our clients request full details of a candidates DBS, please confirm if you are happy for us to provide this on request

YES         NO  

**Rehabilitation of Offenders Act 1974**

Applicants for Healthcare positions are exempt from the Rehabilitation of Offenders Act 1974. You are required to declare prosecutions or convictions, including those considered 'spent' under this Act

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 conviction, an order binding you over or a caution in the UK or any country?	Yes:
	No:
If <b>yes</b> , please provide details of the nature of the criminal offence, order binding you over a caution, including the approximate date, the offence and the authority and country which dealt with the offence. <b>You should do this via e-mail to your recruitment consultant</b>	

**Professional misconduct**

Have you been, or are you currently subject to any fitness to practice proceedings, or suspension from an employer, or any such pending or threatened against you either in the UK or any other country?	Yes:
	No:
If <b>yes</b> , please provide details of the nature of the proceedings undertaken, or contemplated, including the approximate date of proceedings, country where the proceedings were undertaken and the name and address of the licensing or regulatory body concerned. <b>You should do this via e-mail to your recruitment consultant</b>	

**Professional Indemnity**

Please tick if you have included your certificate of Professional Indemnity			
MPS/ MDU / Other	Policy number:	Renewal date:	

I confirm that I will always ensure that I have sufficient indemnity cover for the work I undertake

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Consent:**

You hereby expressly consent to us collecting and processing your personal data and disclosing this information to relevant third parties for the purpose of seeking employment on your behalf?	Please tick :	<input type="checkbox"/>
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You hereby expressly consent to us auditing your personal data we hold for compliance and quality assurance purposes?	Please tick :	<input type="checkbox"/>
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**Declaration**

I confirm I have read this document fully and that all the information give to Coben Healthcare is correct to the best of my knowledge and belief. I understand that a false declaration may lead to refusal to this application. If, while I am working with Coben Healthcare, any of the information provided changes, I agree to notify Coben Healthcare in writing immediately.

I understand and agree to Coben Healthcare disclosing this information to their clients for the purpose of finding me assignments.

I have read, understood and accpet the information contained within the staff handbook

I have read and agree to adhere to the Coben Healthcare Terms of Engagement

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_