FLEXY HEALTH CARE LTD

STAFF RECRUITMENT & REGISTRATION APPLICATION FORM

Company Reg No: 13686643
Tel: 07903 748010 / 07368 937793
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Web: https://flexyhealthltd.com/

PLEASE NOTE: IT IS A MANDATORY REQUIREMENT TO FULLY COMPLETE ALL SECTIONS OF THIS FORM

Date of Application:		**Band / Grade:**	
Position Applied For:	☐ RGN ☐ RMN ☐ RNLD ☐ ODP ☐ HCA / HCSW ☐ Senior Carer Other: _____		

1. PERSONAL INFORMATION

Title (Mr/Mrs/Miss/Ms):		**Known As:**	
First Name(s):		**Middle Name(s):**	
Surname:			
Home Address:			
Postcode:		**Email Address:**	
Telephone Number:		**Mobile Number:**	
Date of Birth:		**National Insurance No:**	
Valid Driving License?	☐ Yes ☐ No	**Use of a Car?**	☐ Yes ☐ No

2. EMERGENCY CONTACT DETAILS

Emergency Contact Name:		**Relationship to You:**	
Contact Telephone No:		**Alternative Phone No:**	

3. PROFESSIONAL REGISTRATION (NMC / HCPC / OTHER)

NMC / HCPC PIN No:		**PIN Expiry Date:**	____ / ____ / _____
NMC Part(s) of Register:		**Union / Professional Body:**	
Union Membership No:			

4. RIGHT TO WORK IN THE UK

Nationality:		**Passport Number:**	
Passport Date of Issue:	____ / ____ / _____	**Passport Expiry Date:**	____ / ____ / _____
Visa Type / Status:		**Visa Expiry Date:**	____ / ____ / _____
Home Office Share Code:			

Right to Work Confirmation: I confirm that I possess the legal right to work in the United Kingdom and will provide original documentation to Flexy Health Care Ltd upon request.

Signature: _____	Date: ____ / ____ / _____

5. PROFESSIONAL REFERENCES (PAST 3 YEARS)

Please provide details of referees below covering your past 3 years of employment. All references must be from a direct line manager or supervisor supporting the role and specialty applied for.

REFERENCE 1 (Current / Most Recent Employer)

Referee Name:		**Contact Number:**	
Position / Job Title:		**Email Address (Work):**	
Company / Trust Name:		**Capacity Known To You:**	
Company Address & Postcode:			
Employment Dates:	From: ____ / ____ / _____ To: ____ / ____ / _____		

REFERENCE 2

Referee Name:		**Contact Number:**	
Position / Job Title:		**Email Address (Work):**	
Company / Trust Name:		**Capacity Known To You:**	
Company Address & Postcode:			
Employment Dates:	From: ____ / ____ / _____ To: ____ / ____ / _____		

REFERENCE 3

Referee Name:		**Contact Number:**	
Position / Job Title:		**Email Address (Work):**	
Company / Trust Name:		**Capacity Known To You:**	
Company Address & Postcode:			
Employment Dates:	From: ____ / ____ / _____ To: ____ / ____ / _____		

Reference Consent: I hereby give permission for Flexy Health Care Ltd to contact my referees and share references with third-party healthcare clients where relevant to my deployment.

Signature: _____	Date: ____ / ____ / _____

6. EMPLOYMENT HISTORY & CV DECLARATION

Current Profession:		**Current Job Title:**	
Current Place of Work:			
Reason for Leaving Previous Job (if not working):			

10-Year CV History Confirmation: I confirm that I have supplied a full CV detailing my complete employment history covering a minimum of 10 years (or back to my original professional qualification) without unexplained gaps.

Signature: _____	Date: ____ / ____ / _____

7. CLINICAL EXPERIENCE & COMPETENCY MATRIX

Please tick [☐] and initial all clinical areas where you hold verifiable experience and are fully competent:

☐ A&E / Emergency Care _____	☐ Acute Mental Health _____	☐ CCU / HDU _____
☐ Cardiology _____	☐ Catheterisation _____	☐ Community Nursing _____
☐ Chemotherapy _____	☐ Dementia Care _____	☐ Elderly Care / Residential _____
☐ Gynaecology _____	☐ Haematology _____	☐ Health Visiting _____
☐ ITU / Critical Care _____	☐ Midwifery _____	☐ Neonates / NICU _____
☐ ODP / Operating Theatres _____	☐ Occupational Health _____	☐ Orthopaedics _____
☐ Oncology _____	☐ Practice Nursing _____	☐ Palliative / End of Life Care _____
☐ Prison Healthcare _____	☐ Paediatric Care / PICU _____	☐ Pressure Care / Bandaging _____
☐ Radiology _____	☐ Renal Dialysis _____	☐ Re-ablement Care _____
☐ Sexual Health _____	☐ Spinal Injury Care _____	☐ Stroke Rehabilitation _____
☐ Triage Assessment _____	☐ Urology _____	☐ Venepuncture / Phlebotomy _____
☐ Wound Management _____	☐ Safe Administration of Meds _____	☐ Learning Disability & Autism _____
☐ Other: _____	☐ Other: _____	☐ Other: _____

8. PROFESSIONAL QUALIFICATIONS & EDUCATION

Please provide details of relevant professional qualifications. Original certificates must be presented during compliance verification.

Name of Qualification / Degree	Awarding Institution / University	Date Awarded
		____ / _____
		____ / _____
		____ / _____
		____ / _____

9. BANK DETAILS & PAYMENT MANDATE

Name of Account Holder:			
Bank / Building Society:			
Branch Address & Postcode:			
Account Number (8 digits):		**Sort Code (6 digits):**	____ - ____ - ____
Payment Account Type:	☐ Personal Bank Account ☐ Limited Company Bank Account ☐ Umbrella Company		

*** If operating via your own Limited Company, you must attach a copy of your Certificate of Incorporation, business bank details, and proof of Professional Indemnity Insurance.*

Limited Company / Umbrella Details (If applicable):

Company / Umbrella Name:			
Registered Office Address:			
Company Registration No:		**Postcode:**	

10. PROFESSIONAL MEDICAL INDEMNITY INSURANCE

Indemnity Provider Name:	☐ RCN ☐ Unison ☐ MDU / MPS ☐ Other	**Policy / Membership No:**	
Policy Expiry Date:	____ / ____ / _____		

Payroll Notice: Flexy Health Care Ltd processes payroll weekly in arrears into your nominated account upon receipt of signed client timesheets.

Bank Account Confirmation: I confirm that the bank details provided above are accurate and hereby authorise Flexy Health Care Ltd to remit earnings to this account.

Signature: _____	Date: ____ / ____ / _____

11. REHABILITATION OF OFFENDERS ACT DECLARATION

The position you are applying for is listed in Schedule 1, Part II of the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975. As such, you are required to declare any convictions, cautions, reprimands, or final warnings, including those normally considered 'spent'.

Have you ever received a Criminal Conviction?	**YES / NO**
Have you ever received a Police Caution, Reprimand, or Final Warning?	**YES / NO**
Are you currently under investigation by the Police or any professional body (e.g. NMC/HCPC)?	**YES / NO**
Do you have any criminal prosecutions pending against you?	**YES / NO**
Has there ever been any allegation or suggestion that you are unsuitable to work with vulnerable adults or children?	**YES / NO**

If you answered YES to any of the above, please attach a full written statement in a sealed envelope marked 'Private & Confidential' for the Compliance Manager.

DBS Information Sharing Consent: I understand that my Enhanced DBS Certificate information may be shared with healthcare clients considering deploying me on a temporary or permanent assignment. I agree to notify Flexy Health Care Ltd immediately of any changes affecting my DBS status.

Signature: _____	Date: ____ / ____ / _____

12. OVERSEAS POLICE CLEARANCE CHECK

Have you lived or spent a continuous period of 6 months or more outside the UK in the past 5 years?	**YES / NO**

If YES, you must provide an official Overseas Police Certificate from the country/countries of residence, issued within the last 3 months prior to registration with Flexy Health Care Ltd.

13. WORKING TIME REGULATIONS (WTR) 48-HOUR OPT-OUT AGREEMENT

I agree with Flexy Health Care Ltd that the 48-hour average weekly limit in Regulation 4(1) of The Working Time Regulations 1998 shall not apply to me, allowing my average working hours to exceed 48 hours per seven-day period.

I agree to comply with all company policies regarding the recording of working hours. I understand that I may terminate this opt-out agreement at any time by giving one month's written notice to Flexy Health Care Ltd.

Signature: _____	Date: ____ / ____ / _____

14. DECLARATION OF ACCURACY

I hereby confirm that the information provided in this Application Form is, to the best of my knowledge, complete, true, and accurate in all respects. I understand that knowingly providing false, misleading, or incomplete information will result in immediate termination of my registration with Flexy Health Care Ltd.

Signature: _____	Date: ____ / ____ / _____

15. DATA PROTECTION & GDPR CONSENT

I understand that Flexy Health Care Ltd will collect and process personal data about me (including sensitive health and criminal record data) for recruitment, compliance, payroll, and placement purposes in accordance with UK GDPR and the Data Protection Act 2018. I give my explicit consent for my compliance file to be shared with prospective healthcare clients and regulatory auditors.

Signature: _____	Date: ____ / ____ / _____

16. HEALTH ASSESSMENT & GP DETAILS

Please indicate which of the following statements applies to you (circle **A** or **B**):

[A] I am not aware of any health condition or disability that might impair my ability to undertake effectively the duties of the healthcare position I am applying for.

[B] I have a health condition or disability that might affect my work and may require special reasonable adjustments to be made to my role or workplace.

General Practitioner (GP) Contact Details:

GP Name:		**Practice Name:**	
Practice Address:			
Practice Telephone No:			

** Note: Flexy Health Care Ltd will only contact your GP with your prior written consent.*

17. PROFESSIONAL REVALIDATION & LAST APPRAISAL (QUALIFIED STAFF)

Revalidation Due Date:	____ / ____ / _____	**Date of Last Appraisal:**	____ / ____ / _____

18. DOCUMENT VERIFICATION CHECKLIST FOR ONBOARDING

Please bring ALL original documents listed below to your registration interview, alongside this fully completed application form. Your compliance file must be verified prior to deployment.

☐ Full Detailed CV (10-yr history)	☐ Current Mandatory Training Certs	☐ 1 Recent Passport Photo
☐ Valid Passport / UK Birth Cert	☐ Valid UK Driving Licence	☐ Visa / Biometric Residence Permit
☐ Share Code (Right to Work)	☐ 2 Proofs of Address (< 3 months)	☐ Marriage / Divorce Cert (if applicable)
☐ Proof of National Insurance No.	☐ Blood Immunity Results (Hep B)	☐ Original Qualification Certificates
☐ Varicella, Rubella & Measles Proof	☐ NMC Statement of Entry / PIN	☐ Proof of TB Scar / BCG Cert
☐ Enhanced DBS Certificate (Copy)	☐ DBS Update Service Reference	☐ Overseas Police Check (if applicable)

19. PATIENT SAFETY & EQUAL OPPORTUNITIES POLICY

Patient & Public Safety Commitment: Flexy Health Care Ltd operates strictly under official NHS and CQC guidance regarding the sharing of relevant information between healthcare organisations concerning worker performance or conduct where patient safety is identified as a risk.

Equal Opportunities Employer: Flexy Health Care Ltd is committed to ensuring that all temporary workers and applicants receive equal treatment regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, or sexual orientation.

20. INTERNAL OFFICE COMPLIANCE SIGN-OFF (OFFICE USE ONLY)

Interviewing Manager:	Flex Nyandebvu / Officer	**Interview Date:**	____ / ____ / _____
Clinical Test Status:	☐ Passed ☐ N/A	**Numeracy / Medication Test:**	☐ Passed ☐ N/A
DBS Check Status:	☐ Cleared ☐ Update Service	**Right to Work Verified:**	☐ Yes ☐ Pending
Manager Approval Signature:		**Final Onboarding Status:**	☐ APPROVED

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