

Acute

M E D I C A L

TEL: 01472 354768

Park House, PO Box 370
Grimsby, NE Lincolnshire.
DN32 0XQ

FAX: 01472 235889

APPLICATION FORM

PERSONAL DETAILS:

Surname _____

Forenames _____

D.O.B (dd/mm/yy) _____

National Insurance
Number: _____

Address

Postcode _____

Telephone: _____

Telephone(2): _____

Email address: _____

Payment method:

Please indicate: By Cheque (Yes / No) or directly to bank, details given below:

Account Holder's Name _____

Bank _____

Branch Address _____

Sort Code _____

Account No. _____

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APPLICATION FORM

WHICH SUB-SPECIALTY AREAS OF PSYCHIATRY ARE YOU INTERESTED IN?

General Adult	Yes ()
Forensic Psychiatry	Yes ()
Psychogeriatrics	Yes ()
Child and Adolescent	Yes ()
Substance Misuse	Yes ()
Learning Disability	Yes ()
Liaison Psychiatry	Yes ()

TO REGISTER YOU WILL NEED:

- A comprehensive CV, which includes your most recent employment.
- Names and contact details for two referees.
- GMC registration details.
- A completed medical questionnaire.
- Information on Hepatitis B status and vaccination history.
- A declaration of any convictions/cautions.
- Doctors who are non EC Nationals should provide a copy the relevant Work Permit.

And if available:

- National Insurance Number.
- A copy of an Occupational Health Examination within the last 2 years.
- A copy of a Police Check (available through your local police station) obtained within the last year.

ADVICE:

If you require advice we are more than pleased to assist and welcome your inquiry.



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DECLARATION OF HEALTH

I declare that I will comply with the Occupational Health Processes of the Client Hospitals where I am employed.

I declare also that I am aware of the General Medical Council's advice to doctors "If your health may put patients at risk", contained in the document "Good Medical Practice" Third Edition May 2001 as set out below:

"If your health may put patients at risk.

59. If you know that you have a serious condition which you could pass on to patients, or that your judgment or performance could be significantly affected by a condition or illness, or its treatment, you must take and follow advice from a consultant in occupational health or another suitably qualified colleague on whether, and in what ways, you should modify your practice. Do not rely on your own judgment of your risk to patients.

60. If you think you have a serious condition which you could pass on to patients, you must have all the necessary tests and act on the advice given by a suitably qualified colleague about necessary treatment and/or modifications to your clinical practice."

Signature _____ Date _____

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STRICTLY IN CONFIDENCE
HEALTH PROFILE

Name _____

Last Occupational Health Examination:

Hospital: _____

Date: _____

Name and address of General Practitioner:

Name: _____

Address _____

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STRICTLY IN CONFIDENCE
HEALTH PROFILE

Have you ever had:

Additional information:

Tuberculosis, asthma, bronchitis
or chest complaints?

Yes() No()

Chest pains, heart conditions
or raised blood pressure?

Yes() No()

Blackouts, fits
or attacks of giddiness?

Yes() No()

Depression, mental illness
or nervous breakdown?

Yes() No()

Rheumatism or Arthritis?

Yes() No()

Back Trouble?

Yes() No()

Typhoid, paratyphoid
or dysentery?

Yes() No()

Digestive
or bowel disorder?

Yes() No()

Diabetes, thyroid
or other glandular trouble?

Yes() No()

Bladder or kidney trouble?

Yes() No()

Dermatitis or skin trouble?

Yes() No()

Varicose veins?

Yes() No()

Any other accident operation
or illness?

Yes() No()

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STRICTLY IN CONFIDENCE HEALTH PROFILE

Have you ever had:

Additional information:

Do you have any reason to believe you may be infected with any communicable disease? Yes() No()

Any other current or recent medical condition or treatment, which might affect your performance at work? Yes() No()

Any illness or medical condition that prevented you from attending work or your normal duties or activities for more than one week during the year? Yes() No()

Do you have any physical disabilities including defect of sight or hearing? Yes() No()

Do you smoke? Yes() No()

How many units of alcohol do you drink per week? None() Amount in number ()

Vaccination and Immunization History:

Tetanus Yes () No () Don't know () Date _____

Poliomyelitis Yes () No () Don't know () Date _____

Diphtheria Schick Test Yes () No () Don't know () Date _____

Tuberculosis BCG Yes () No () Don't know () Date _____

Varicella (chicken pox) Yes () No () Don't know () Date _____

Last chest X-ray Yes () No () Don't know () Date _____

Hepatitis B Yes () No () Don't know () Date _____
(Please send copy of Hepatitis B report)

Signature _____ Date _____



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REHABILITATION OF OFFENDERS ACT 1974

DECLARATION

By virtue of the Rehabilitation of Offenders Act 1974 (Exceptions) (Amendments) Order 1986, the provision of section 4.2 of the Rehabilitation of Offenders Act 1974 do not apply to any employment which is concerned with the provision of health services and which is of such a kind as to enable the holder to have access to persons in respect of such services in the course of their normal duties.

Employment as a doctor requires a declaration of all convictions and cautions, which include any “spent” convictions as defined by the Rehabilitation of Offenders Act 1974.

Some hospital based roles for doctors such as when there is substantial access to children and/or or in most forensic settings involve a check against the applicant’s police records.

Please complete the relevant declaration from the two choices below:

A) I have no convictions or cautions of a criminal offence to declare.

Signature: _____ Date _____

B) I declare the following list of my criminal convictions and cautions:

DATE	OFFENCE	OUTCOME

Signature: _____ Date _____