Lincoln Recruitment Specialists

Application Form

PLEASE READ
Please note all fields with (*) are mandatory so you will not be able to progress without completion.
Once completed, please email or post the form back to us.

PERSONAL DETAILS*

Title:	Position:
Surname:	Mobile No.:
First Name:	Email Address:
Date of Birth:	☐ Male ☐ Female
Address:	

EMERGENCY CONTACT*

Name:	Telephone No.:
Relationship:	Mobile No.:

SOURCE

Where did you hear about us?	
☐ Lincoln Healthcare Website	☐ Irish Jobs
☐ Referral	☐ Indeed
☐ Others *(Please specify):*	

NATIONALITY AND ELIGIBILITY TO WORK

Do you hold an Irish/EU Passport?	☐ Yes ☐ No
If NO, please specify what visas you currently hold:	
Date of Expiration:	Nationality:

What kind of work are you interested in? *(Please tick all applicable boxes)*	
☐ Learning Disabilities	☐ Nursery
☐ Psychiatric	☐ Playschemes
☐ Challenging Behaviour	☐ After School Clubs
☐ NHS/Hospitals	☐ Children's Homes
☐ Nursing Homes	☐ Social Work
☐ Residential Homes	☐ Home Care/Live In

Which work shift do you prefer?	☐ Early ☐ Late ☐ Night
Do you have any other work commitments?	☐ Yes ☐ No
Do you want to work?	☐ Full-time ☐ Part-time

THIS SECTION SHOULD BE COMPLETED BY NURSES ONLY.

SKILLS AND EXPERIENCE
Please complete the following section and indicate whether you have received a training certificate for the skill or whether the skills are based on experience. If based on experience please indicate length of experience.

SKILL	CERT	EXP	NOTES
Psychiatry			
Medical/Surgical Ward			
IV Skills			
Tracheotomy			
PEG Feeds			
Administering Injections			
Vaccinations			
Male Catheterisation			
Female Catheterisation			
Palliative Care			
ITU			
A & E			
Wound Care			
Nurse Practitioner			
System One User			
Smart Card User			
Other skill(s):			

PROFESSIONAL HEALTHCARE REFERENCES

Reference 1	
Organisation:	
Referee Name:	Referee Position:
Referee Phone No.:	Referee Email:
Your job title within this organization:	Period of Employment:
Reference 2	
Organisation:	
Referee Name:	Referee Position:
Referee Phone No.:	Referee Email:
Your job title within this organization:	Period of Employment:
Reference 3	
Organisation:	
Referee Name:	Referee Position:
Referee Phone No.:	Referee Email:
Your job title within this organization:	Period of Employment:

BANK ACCOUNT DETAILS

PPSN (Personal Public Service Number):	Account Name:
Account No.:	IBAN:
Sort Code:	BIC:

MEDICAL HISTORY FORM

Do you have any illness/impairment/disability (physical or psychological), which may affect your work?	☐ Yes ☐ No
Have you ever had any illness/impairment/disability (physical or psychological), which may been caused or made	☐ Yes ☐ No
Do you think you may need any adjustments or assistance to help you to carry out your work?	☐ Yes ☐ No
Are you having, or waiting for treatment (including medication) or investigations at present?	☐ Yes ☐ No
If your answer is yes, please provide further details of the condition, treatment and dates:	
If you have selected YES to any of the above question, you shall provide further details. Failure to provide details may result in rejection of application.	
Tuberculosis	
Have you lived continuously in Ireland for the last 5 years?	☐ Yes ☐ No
If you have answered NO to the above, please list all of the countries that you have resided over the last 5 years, including duration of stay and dates, e.g. January 2015 to May 2015.	
Have you had a BCG vaccination in relation to Tuberculosis?	☐ Yes ☐ No
Shingles or Chicken Pox	
Have you ever had chicken pox or shingles?	☐ Yes ☐ No
If YES, please specify the date:	
Proof of Immunity	
Have you ever had the following immunization?	
HEP B Vaccination	☐ Yes ☐ No
Rubella, Measles & Mumps	☐ Yes ☐ No
Varicella / Chicken Pox / Shingles	☐ Yes ☐ No
Proof of Immunity – EPP Candidates Only	
Hepatitis B Surface Antigen	☐ Yes ☐ No
Hepatitis C	☐ Yes ☐ No
HIV	☐ Yes ☐ No

Proof of Immunity (*please send the following*):

- **Varicella:** You must provide a written statement to confirm that you have had chicken pox or shingles however we strongly advise that you provide serology test result showing varicella immunity.
- **Tuberculosis:** We require an occupational health/GP certificate of a positive scar or a record of a positive skin test result (Do not Self Declare)
- **Rubella, Measles & Mumps:** Certificate of "two" MMR vaccinations or proof of a positive antibody for Rubella and Measles
- **Hepatitis B:** You must provide a copy of the most recent pathology report showing titre levels of 100lu/l or above

Proof of Immunity - EPP Candidates Only *(please send the following):*

- **Hepatitis B:** Surface Antigen Evidence of a negative surface antigen test. Report must be an identified validated sample (IVS).
- **Hepatitis C:** Evidence of a negative antibody test. Report must be an identified validated sample (IVS).
- **HIV:** Evidence of a negative antibody test. Report must be an identified validated sample (IVS).

DECLARATION

☐ The given information is true to the best of my belief.

☐ I agree to inform my employer of any health issues so that my health and safety can be protected whilst at work.

Signature:	
Print name:	Date Signed: