

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:					
EMERGENC	CONTACT*				
Name:	Telephone No.:				
Relationship:	Mobile No.:				
sot	IRCE				
Where did you hear about us?					
Lincoln Healthcare Website	☐ Irish Jobs				
Referral	☐ Indeed				
Others (Please specify):					
NATIONALITY AND E	LIGIBILITY TO W	ORK			
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.

Psychiatry Medical/Surgical Ward IV Skills Tracheotomy PEG Feeds Administering Injections		
IV Skills Tracheotomy PEG Feeds		
Tracheotomy PEG Feeds		
PEG Feeds		
Administering Injections		
0 ,		
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:	nisation:		
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:	nis organization: Period of Employment:		
Reference 3			
Organisation:			
Referee Name:	Referee Position:		
Referee Phone No.:	Referee Email: Period of Employment:		
Your job title within this organization:			

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 a	iffect 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 pro	esent?	☐ Yes	☐ No	
If your answer is yes, please provide further details of the condition, treatment and da	ites:			
If you have selected YES to any of the above question, you s Failure to provide details may result in rejection		i.		
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:				