

**Application Form**

(Please refer to the Guidance Notes for assistance in completing this form)

**Name**

Surname	
Any other surnames you have had	
Forenames	
Nationality	
Sex	

**Contact Details**

Current Address	Permanent Address (if different)

	Home	Work	Mobile
Telephone			
Fax			
E-mail			

**Personal**

Birth date
National Insurance number
In case of emergency, whom should we notify? (Name, Address and phone number)

**Medical Registration  
(see Guidance Note 1)**

**Private Medical Insurance  
(see Guidance Note 1)**

Registration No.	Membership No.
Full / Limited	Organisation
Expiry date	Expiry date

**Bank Details**

Bank / Building Society		
Branch		
Sort Code		
A/c Name (e.g. Dr. J. Brown)		
A/c Number		
Building Society Roll Number		
Tick here if you are considering payment through a Limited Company.	Yes	No

**Availability (see Guidance Note 2)**

Full-time	
Nights	
Weekends	
Holidays	
Willing to travel? If so, please state localities.	
Grades	

**Qualifications (see Guidance Note 3)**

Degree	Awarded by (Institution)	Country	Year

**Appointments (see Guidance Note 4)**

	From	To
Current post		
Hospital		
Previous post		
Hospital		
Previous post		
Hospital		

**Mandatory Training (see Guidance Note 5)**

Have you undertaken mandatory Health & Safety training?	Yes	No
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**Life Support Training (see Guidance Note 6)**

Do you hold a valid life support certificate such as ALS, ATLS, APLS, EPLS, etc.?	Yes	No
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**Basis of Right to Work in UK (see Guidance Note 7)**

Nationality			
Permanent Resident?	Yes	No	Please submit evidence.
Or other right to work in the UK?	Please submit evidence.		

**Skills (see Guidance Note 8)**

Please answer Yes / Limited / No / Comment
Epidural techniques
Obstetric anaesthesia
Intensive therapy
Popumet Certificate held?
Other

**Years Experience in Anaesthesia**

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**Consultant Anaesthetist Referees (see Guidance Note 9)**

Name		
Title		
Hospital		
Email		
Length of time s/he has known you		
May we write to this Consultant for a reference at present?	Yes	No
Name		
Title		
Hospital		
Email		
Length of time s/he has known you		
May we write to this Consultant for a reference at present?	Yes	No

## Criminal Convictions (see Guidance Note 10)

*By virtue of the Rehabilitation of Offenders Act 1974 (Exemptions) (Amendments) Order 1986, the provision of sections 4.2 and 4.3 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 receipt of such services in the course of his/her normal duties. Your answer to the following question must include any 'spent' convictions. This may or may not affect your application. You also agree to inform The Anaesthetists Agency of any convictions or cautions that you subsequently incur.*

1. Do you have any convictions or cautions?

Please write your answer.....

2. Are you currently the subject of any criminal proceedings (for example charged or summoned but not yet dealt with) or any police investigation?

Please write your answer.....

3. Have you had any proceedings or suspensions against you of which may not have necessarily lead to a GMC / GDC complaint or criminal record?

Please write your answer .....

If the answer to 1 and/or 2 and/or 3 above is 'Yes', please give full details on a separate piece of paper and attach it to this application form.

Signed:..... Date:.....

*The Care Standards Act 2000 requires that a check be made on you with the **Criminal Records Bureau**. The information provided in the subsequent disclosure will be considered prior to you being engaged with The Anaesthetists Agency and may or may not affect your application. Failure to agree to apply for a disclosure to the Criminal Records Bureau will result in The Anaesthetists Agency being unable to register you for work. An adverse inference may be drawn from any difference between your answer to the questions above and the disclosure issued by the CRB.*

I agree to apply for disclosure to the Criminal Records Bureau and have completed the separate application form accordingly.

I agree to permit The Anaesthetists Agency to inform a third party of the details of my CRB check in order to secure work on my behalf.

Signed:.....Date:.....

**Security (see Guidance Note 11)**

Please supply us with one photograph of yourself. Print your name on the back, and have a witness sign and date the back of the photograph and also the declaration below.

**DECLARATION**

I certify that the accompanying photograph I have signed and dated is a true likeness of:

-----

whom I have known for \_\_\_\_\_ (in words) years.

Name: -----  
Please print

Signed: -----

Address: -----  
-----  
-----

TEL (daytime): -----

## Declaration & Agreement

1. I declare that the above information is true. I understand that knowingly giving false information will disqualify me from registration with The Anaesthetists Agency.

2. I confirm that the persons listed above have consented to act as referees.

3. I authorise The Anaesthetists Agency to obtain references from the named referees and to obtain reports on my work and behaviour during locums arranged by the Agency from consultant anaesthetists at the hospitals involved, and to submit the same to whom and in such manner as in the opinion of the Agency may appear appropriate.

4. I confirm that there is no contractual, legal or health reason why I should not undertake locum work.

5. I understand that registration does not guarantee engagement or assignments and that I shall receive payment only during the period of such engagement or assignment.

6. I agree that I am an employee of the Agency for the period of engagements or assignments only. For all other purposes I am to be regarded as self-employed.

7. I understand that I shall be responsible for all expenses of a personal and professional nature arising out of such engagement or assignment.

8. I have read the conditions of engagement and agree to be bound by them.

Name: \_\_\_\_\_

Please print

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

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

**WORKING TIME DIRECTIVE  
OPT-OUT AGREEMENT**

The Working Time Directive requires that a worker's average working time must not exceed 48 hours per week unless the worker agrees in writing to exceed the limit.

If temporary employees are to lawfully work more than 48 hours, they must sign an opt-out agreement to this effect.

If you are prepared to work more than 48 hours per week, please sign and return the agreement below as soon as possible in order that we may lawfully employ you even if your hours exceed this.

- - - - -

I agree that I may work for more than 48 hours a week.

I agree that if I wish to retract this that I will give 4 weeks notice in writing to The Anaesthetists Agency.

Name: \_\_\_\_\_  
Please print

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

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

## **The Anaesthetists Agency Terms & Conditions of Engagement for Doctors who are our EMPLOYEES (see Guidance Note 12)**

1. The Anaesthetists Agency (the Agency) is an employment business. You shall be employed by us under a “contract of service”, ie a contract of employment.
2. The Agency agrees to use its best endeavours to introduce the anaesthetist (the doctor) registered with the Agency, to hospitals and other medical establishments for engagements and/or assignments which it deems are suitable for the doctor by reason of his or her qualifications and experience.
3. The Agency reserves the right to terminate the registration with it of the doctor without notice.
4. The offer to the doctor through the Agency of an engagement or assignment shall be subject to approval by the hospital or other medical agency concerned, to which the doctor's professional details, references and medical details shall be submitted, but the doctor is not obliged to accept such offer.
5. In the event of the doctor accepting an offer in accordance with paragraph 3 hereof and subsequently being unable or unwilling for whatever reason to commence or complete the engagement or assignment, the doctor undertakes to notify the Agency accordingly forthwith. The doctor shall give the Agency as much notice as possible of any such change and, in every case, at least twenty-four hours notice shall be given.
6. *“The hourly rate of pay shall not be less than the statutory minimum wage.”*

(Employment law requires us either to include this phrase, or else state rates, which are complicated, often change and become out of date, and are sometimes negotiable. This is easier, and certainly true!)

Payment in respect of engagements or assignments shall be made to the doctor at our current rates, less any deductions in respect of or on account of Income Tax and National Insurance Contributions as may be required by law.

Payment will be made by the Agency on Friday of each week, to those doctors submitting a valid completed timesheet by 11 am on Tuesdays. No payment shall be made in respect of periods during which no engagement or assignment has been arranged, nor during which the doctor is on holiday or unavailable for any other reason, unless the Agency is required to make such payment(s) under employment law in force at the time. The Agency shall pay the doctor whether or not the hospital or client pays the Agency.

7. Holiday pay will accrue to the doctor at the rate of one hour for every twelve hours worked, ie at 8.3% of gross pay. Holiday pay should be drawn for use during four weeks holiday per year. No other pay is payable in respect of holiday taken.
8. Throughout the period during which the doctor is registered with the Agency the doctor shall:
  - (i) maintain such registration with the General Medical Council as may, in the opinion of the Agency, be appropriate;
  - (ii) arrange, for the duration of a locum, membership of a recognised medical defence organisation providing professional indemnity insurance, if a locum position accepted by the doctor requires such insurance and the doctor has been informed of this

requirement by the Agency;

(iii) produce, upon commencement of an engagement or assignment, to the appropriate hospital or authority and otherwise on demand, proof of identity and certificates of registration and membership referred to in sub-clauses (i) and (ii) above.

9. During the course of any engagement or assignment the doctor shall behave as if under the direct control of the hospital or other medical agency and will observe all regulations applicable to him/her and comply with all lawful requests relating to the performance of his or her duties.

10. The Agency reserves the right without reason to terminate any engagement or assignment at any time. Though the doctor shall be entitled to notice of one hour only, as much notice as possible shall be given as a matter of courtesy.

11. The doctor agrees at all times:

(i) to indemnify the Agency in respect of any claims, costs, expenses or otherwise arising out of any engagement or assignment;

(ii) not to act in any manner detrimental to the interests of the Agency;

(iii) to perform the duties allocated to him or her by any hospital or other medical agency in a proper professional manner and to the best of his or her ability.

12. The doctor agrees that, in the event of an Inquiry at a hospital, the doctor will attend the hospital if required to do so, regardless of whether his or her work with the hospital has been completed or his or her contract with the Agency has been terminated or the Agency has ceased to exist.

**Signed:**

Name: \_\_\_\_\_

Please print

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

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

**Please return your completed registration documents to:  
The Anaesthetists Agency  
Solent House  
5 Bath Road  
Lymington  
Hampshire  
United Kingdom  
SO41 3RU**

## **The Anaesthetists Agency Terms & Conditions of Engagement for LIMITED COMPANIES OR SELF-EMPLOYED DOCTORS (see Guidance Note 12)**

1. The Anaesthetists Agency (the Agency) is an employment business. You will be engaged under a Contract for Services, ie a contract to provide a service. You will not be employed by us.
2. The Agency agrees to use its best endeavours to introduce the anaesthetist (the doctor) registered with the Agency, to hospitals and other medical establishments for engagements and/or assignments which it deems are suitable for the doctor by reason of his or her qualifications and experience.
3. The Agency reserves the right to terminate the registration with it of the doctor without notice.
4. The offer to the doctor through the Agency of an engagement or assignment shall be subject to approval by the hospital or other medical agency concerned, to which the doctor's professional details, references and medical details shall be submitted, but the doctor is not obliged to accept such offer.
5. In the event of the doctor accepting an offer in accordance with paragraph 3 hereof and subsequently being unable or unwilling for whatever reason to commence or complete the engagement or assignment, the doctor undertakes to notify the Agency accordingly forthwith. The doctor shall give the Agency as much notice as possible of any such change and, in every case, at least twenty-four hours notice shall be given.
6. *“The hourly rate of pay shall not be less than the statutory minimum wage.”*  
(Employment law requires us either to include this phrase, or else state rates, which are complicated, often change and become out of date, and are sometimes negotiable. This is easier, and certainly true!)

Payment in respect of such engagements or assignments shall be made to the doctor or to the company supplying the doctor's services to the Agency, at our current rates.

Payment will be made by the Agency on Friday of each week, in respect of those doctors submitting a valid completed timesheet by 11 am on Tuesdays. No payment will be made in respect of periods during which no engagement or assignment has been arranged, nor during which the doctor is on holiday or unavailable for any other reason. The Agency shall pay the company whether or not the hospital or client pays the Agency.

7. You should take four weeks absence or holiday per year but the Agency is not liable to pay any holiday pay during such period(s).
8. Throughout the period during which the doctor is registered with the Agency the doctor shall:
  - (i) maintain such registration with the General Medical Council as may, in the opinion of the Agency, be appropriate;
  - (ii) arrange, for the duration of a locum, membership of a recognised medical defence organisation providing professional indemnity insurance, if a locum position accepted by the doctor requires such insurance and the doctor has been informed of this requirement by the Agency;
  - (iii) produce, upon commencement of an engagement or assignment, to the

appropriate hospital or authority and otherwise on demand, proof of identity and certificates of registration and membership referred to in sub-clauses (i) and (ii) above.

9. During the course of any engagement or assignment the doctor shall behave as if under the direct control of the hospital or other medical agency and will observe all regulations applicable to him/her and comply with all lawful requests relating to the performance of his or her duties.

10. The Agency reserves the right without reason to terminate any engagement or assignment at any time. Though the doctor shall be entitled to notice of one hour only, as much notice as possible shall be given as a matter of courtesy.

11. The doctor agrees at all times:

- (i) to indemnify the Agency in respect of any claims, costs, expenses or otherwise arising out of any engagement or assignment;
- (ii) not to act in any manner detrimental to the interests of the Agency;
- (iii) to perform the duties allocated to him or her by any hospital or other medical agency in a proper professional manner and to the best of his or her ability.

12. The doctor agrees that, in the event of an Inquiry at a hospital, the doctor will attend the hospital if required to do so, regardless of whether his or her work with the hospital has been completed or his or her contract with the Agency has been terminated or the Agency has ceased to exist.

**Signed:**

Name: \_\_\_\_\_  
Please print

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

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

**Please return your completed registration documents to:  
The Anaesthetists Agency  
Solent House  
5 Bath Road  
Lymington  
Hampshire  
United Kingdom  
SO41 3RU**

The Anaesthetists Agency is committed to being an Equal Opportunities Employer. We aim to treat all applicants equally and to ensure that unacceptable prejudices do not influence decisions. We are required to monitor how effectively we do this and would be grateful if you would provide the information requested on this form.

Please complete the form by placing a tick in the classification box applying to you in each section. This information will be used to produce organisational statistics for Equal Opportunities Monitoring.

Please note that this form is separated from any other forms you send us and is not included in our selection process.

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**From which source did you learn of this post?**

- Newspaper
- Website
- Journal
- Word of mouth
- Other

**Section 1:**

Post Details:

Post Title:

Personal Details:

Surname:	First Name:	Title:
Present Address:		
Phone No:	Mobile No:	
Email Address:		
Date of Birth:	Age:	

**Section 2:**

Gender:  Male  Female

Marital Status:  Married  Unmarried

Place of Birth:

Nationality:

**Ethnic Origin:**

Which best describes your <b>racial or cultural origins?</b> (Please mark the appropriate category with a cross)				
White:	British	<input type="checkbox"/>	Irish	<input type="checkbox"/>
	Any other white background <input type="checkbox"/> Please specify			
Mixed/Dual Heritage:	White and Black Caribbean	<input type="checkbox"/>	White and Asian	<input type="checkbox"/>
	White and Black African	<input type="checkbox"/>		
	Any other mixed background <input type="checkbox"/> Please specify			
Asian or Asian British:	Indian	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
	Bangladeshi	<input type="checkbox"/>		
	Any other Asian background <input type="checkbox"/> Please specify			
Black or Black British:	Black African	<input type="checkbox"/>	Somali	<input type="checkbox"/>
	Other African	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>
	Black British <input type="checkbox"/> Please specify			
Chinese:	Any Chinese background <input type="checkbox"/> Please specify			
Any other Ethnic group:	Yemeni	<input type="checkbox"/>	Other Arabic	<input type="checkbox"/>
	Any other ethnic group <input type="checkbox"/> Please specify			

**Disability:**

The Disability Discrimination Act 1995 defines disability as a physical or mental impairment which has a substantial and long term adverse effect on a person's ability to carry out normal day to day activities.

Do you consider yourself to have a disability?  Yes  No

If "yes" please answer the following questions:

Which of the following best describes your disability?

<input type="checkbox"/> Visual	<input type="checkbox"/> Learning Difficulty
<input type="checkbox"/> Speech	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Co-ordination, Dexterity or Mobility	<input type="checkbox"/> Hearing
Other (please specify):	

Please give any information, which may be relevant to your ability to carry out the duties of the job:

--

What arrangements, if any, would you require at the interview stage – wheelchair access, sign language, interpreter, etc.

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**PLEASE RETURN THIS FORM TO  
THE ANAESTHETISTS AGENCY  
THANK YOU.**

## Agency Worker Induction

I confirm I have received induction training (or commit to doing so \*) on the following:

Topic	Tick
Patient Confidentiality and Caldicott Protocols	
Data Protection	
Risk Incident Reporting	
Handling Complaints	
Personal Safety including Lone Working	
Health & Safety including COSHH and RIDDOR	
Fire Safety	
Infection Control including MRSA and C. Difficile	

\* The Anaesthetists Agency can make available relevant training upon receipt of application.

**Additionally, I commit, when on first shift(s) to:**

Obtaining and understanding Trust/Hospital/Clinic policies on:	Tick
Crash Call Procedure	
Hot Spot Mechanisms	
Violent Episode Policy	
Alerting Security Staff	
Fire & Evacuation procedures	

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Recruitment Consultant / Agency:** \_\_\_\_\_

Staff Members' Handbook

PLEASE RETURN TO THE ANAESTHETISTS AGENCY ONCE YOU HAVE READ AND UNDERSTOOD AND SIGNED ALL DECLARATIONS. THANK YOU.

Member's Declaration

This Handbook contains important guidance for your time with us. Please sign below to show you accept its contents.

- I have received, read and understood, and agree to abide by the contents of The Anaesthetists Agency Staff Members' Handbook.

Appraisal Arrangements

Date of last Appraisal: Date of next Appraisal:

- I declare that I have made arrangements for my next appraisal with:

Name of Appraiser: Contact Details:

- I declare that the above Appraiser is on the specialist register and his/her GMC registration number is
I declare that I will inform The Anaesthetists Agency if I am not fit to practice at the commencement of each assignment or if my circumstances change regarding fitness to practice at any stage.

Signed (Locum)

Print Name

Date

Signed (Agency)

Date

I understand that any personal data held by The Anaesthetists Agency is liable to be inspected by the Care Quality Commission and/or Buying Solutions or any other authorised 3rd party.
I DO/DO NOT WISH (please delete as appropriate) for my personal data to be made available to any 3rd party without direct supervision from a member of staff from The Anaesthetists Agency or myself being present.
SIGNED DATED

THIS DECLARATION IS TO BE STORED IN THE CANDIDATE'S PERSONNEL FILE AT THE ANAESTHETISTS AGENCY.

**DECLARATION OF HEALTH**

The contents of this form will remain confidential to our Occupational Health screening service and will not be disclosed to anyone without your written consent.

**1. Personal Details**

Surname:	Forename(s):
Any other surnames you have had:	Male / Female:
Title: Mr / Mrs / Miss / Ms / Doctor / Professor	Date of Birth:
Address:	
Post Code:	

**Contact Details**

Home:	Mobile:
Work:	Email:

**2. Position Applied For**

Please ✓ all boxes which may apply

The specialities that I may be working in whilst an Agency Worker:

<input type="checkbox"/> General Medicine	<input type="checkbox"/> Orthopaedics	<input type="checkbox"/> PICU/NICU
<input type="checkbox"/> General Surgery	<input type="checkbox"/> Accident & Emergency	<input type="checkbox"/> Oncology
<input type="checkbox"/> Theatre	<input type="checkbox"/> Renal	<input type="checkbox"/> Midwifery
<input type="checkbox"/> ITU	<input type="checkbox"/> Paediatrics	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Cardio/Thoracic	<input type="checkbox"/> Community	<input type="checkbox"/> Other please state below
<input type="checkbox"/> Anaesthetics		

This job may involve:

<input type="checkbox"/> working with human blood, tissues, fluids	<input type="checkbox"/> handling animal products
<input type="checkbox"/> working with respiratory sensitisers or laboratory allergens	<input type="checkbox"/> exposure to ionising radiation
<input type="checkbox"/> handling patients	<input type="checkbox"/> genetically modified organisms
<input type="checkbox"/> handling heavy goods	<input type="checkbox"/> exposure prone procedures
<input type="checkbox"/> food handling	<input type="checkbox"/> regular VDU usage
<input type="checkbox"/> driving	<input type="checkbox"/> overseas travel
<input type="checkbox"/> working night shifts	

**For night shift workers:**

How long have you been working nights?

What type of work?

**For night shift workers:**

Have you suffered any health problems that are directly related to working night shifts? Please state:

**3. Work Related History**

	YES	NO	Please give details
Have you been absent from work or full time study due to ill health during the last 12 months?			
Have you ever left or been denied a job on health grounds?			
Have you ever been denied driving licence on health grounds?			
Have you ever suffered from any work related health conditions?			
Have you ever had an accidental sharps injury or exposure to blood/bodily fluids with broken skin or mucous membranes? If YES please state opposite: <ul style="list-style-type: none"> <li>• Date of the incident</li> <li>• Status of source if known</li> <li>• Details of treatment given at time of injury</li> <li>• Details of follow up blood test results / surveillance</li> </ul>			

<b>4. Health History</b>			
<b>Do you have or have you had in the past:</b>	<b>YES</b>	<b>NO</b>	<b>Please give details:</b>
Conditions of the lungs? Asthma / bronchitis / pleurisy / tuberculosis / other chest complaints / coughing up blood / shortness of breath?			
Conditions of the heart? High blood pressure / heart attacks / angina?			
Nervous system disorder? Blackouts / epilepsy / muscular weakness / paralysis? Migraine or persistent headaches?			
Conditions of the digestive system? Irritable bowel syndrome / liver complaints / jaundice / colitis / gastric/duodenal ulcer?			
Conditions of the bones, joints and limbs? Arthritis / rheumatism / back problems / neck or shoulder problems / sciatica / upper limb disorder / tennis elbow / any other conditions?			
Allergies? Including allergies to drugs, animals and pollens			
Skin conditions? Eczema / dermatitis / psoriasis / recent infection / skin cancer?			
Gland trouble? Diabetes / thyroid – overactive / underactive?			
Eye conditions? Restricted vision / glaucoma / iritis / any other conditions?			
Ear conditions? Restricted hearing / tinnitus / ear infections?			
Alcohol or drug problems? Problems related to alcohol or drug usage or dependency?			
Mental illness and/or stress related problems? Nervous breakdown / mental fatigue / anxiety / depression / panic attacks / significant sleep disturbance / stress related problems / eating disorders / self harm / any other conditions?			
Have you consulted a specialist or need any operations other than already stated?			
Have you spent any time in hospital other than already stated?			
Have you consulted your GP in the last 12 months?			
Are you receiving medical treatment at the present time?			
Do you take any regular medication?			
[1] Are you aware of having any disability that is covered by the Disability Discrimination Act?			
Have you any disabilities affecting sight, hearing, standing, sitting, walking, lifting, driving, stair climbing, use of the hands or ability to carry out any work indicated in section 2?			
Have you been in contact with MRSA? If Yes – did you contact Occupational Health? Please detail the treatment you received and state whether you have been cleared. You are required to inform The Anaesthetists Agency immediately should you come into contact with MRSA as stated in your staff member handbook.			
Have you any other health issues that have not been mentioned above or about which you would like to provide further details?			

**[1] Disability Discrimination Act 1995. You would be regarded as disabled if you have a medical condition that has lasted or is likely to last for more than one year and is sufficient to impair normal day-to-day activities. The Anaesthetists Agency is committed to making reasonable adjustments to facilitate individuals with disabilities. Disability does not preclude consideration for employment.**

**5. Vaccination History**

To reduce the need for further blood tests, please provide a laboratory report or certificates signed and dated for your GP / Vaccination Centre or Occupational Health Department as evidence of any of the immunisations you have had as listed below:

<b>Immunisations and Blood Tests</b>	<b>Dates and Results (attach evidence)</b>
Hepatitis B primary course	
Hepatitis B booster(s)	
Hepatitis B antibody blood test	
Varicella (proof of immunity)	
Diphtheria (proof of 10 yearly update/booster)	
Poliomyelitis (proof of 10 yearly update/booster)	
Tetanus (proof of 10 yearly update/booster)	
Rubella (proof of immunity)	
Measles (proof of immunity)	
Mumps (proof of immunity)	
TB skin test e.g. Heaf test	
BCG (protection against TB)	
HIV (negative result for exposure prone procedures)	
Hepatitis C (negative result for exposure prone procedures)	
Hepatitis B Surface Antigen (for exposure prone procedures)	

Clinical Staff - health care workers who perform exposure prone procedures must inform Occupational Health if they suspect or know they are HIV positive.

**DECLARATION FROM AGENCY WORKER**

I declare that the information give within this declaration of health is true and complete to the best of my knowledge. I understand and accept that I may be required to attend for an Occupational Health Assessment.

I understand and accept that further medical information may be requested from my doctor if considered necessary.

I understand that making false statements or failure to declare health problems could lead to removal from the Agency's register. I agree to update this declaration of health on an annual basis.

PRINT NAME:	SIGNATURE:	DATE:
<b>GENERAL PRACTITIONER DETAILS</b>		
GP Name:		
Address:		
Post Code		