

## **TTM –Nurse Registration Pack.**

**Dear Nurse,**

Please find enclosed our application form to register as a TTM Agency Nurse. Please fill in the relevant details in the application pack and send it back to us with as much information as possible to the address below.

Compliance Department,  
TTM Recruitment,  
Ballymaley  
Ennis  
Co. Clare  
Ireland

**Phone:** +353 (0)65 6869300

**Fax:** +353 (0)65 6869303

**E -mail:** [info@ttm.ie](mailto:info@ttm.ie)

If you have any queries in relation to the registration pack or required documents, please do not hesitate to contact a member of the Nursing team on 065-6869300. We will be in touch once we receive your complete application form.

Kindest regards,

The Nursing Team, TTM.

## REGISTRATION FORM

### Personal Details:

Name:			
Surname:			
Permanent address in Ireland			
Telephone No.			
Mobile No.			
Email address:			
Nationality:			
Sex:	<b>Female</b>		<b>Male</b>
Date of birth:			

### EDUCATION

Name and address of Nursing training School you attended			
Phone No:			
Dates:	<b>From</b>		<b>To</b>
Qualifications obtained:			

### Other relevant education details.

Name and address of Nursing training School you attended			
Phone No:			
Dates:	<b>From</b>		<b>To</b>
Qualifications obtained:			

## GENERAL

An Bord Altranais PIN	
Qualification Types:	
Union Membership:	
Union Pin:	
Date of last Moving and Handling Course:	
Date of last CPR course:	
Date of last IV course:	

## EMPLOYMENT HISTORY

### Current / Previous Employment 1

Name:		
Employer Address:		
Position Held/ Type of ward.		
Dates:	<b>From:</b>	<b>To:</b>

### Previous Employment 2

Name:		
Employer Address:		
Position Held/ Type of ward.		
Dates:	<b>From:</b>	<b>To:</b>

### Previous Employment 3

Name:		
Employer Address:		
Position Held/ Type of ward.		
Dates:	<b>From:</b>	<b>To:</b>

### Previous Employment 4

Name:		
Employer Address:		
Position Held/ Type of ward.		
Dates:	<b>From:</b>	<b>To:</b>

### REFERENCE DETAILS

#### Referee 1(Grade no less than a CNM1)

<b>Name:</b>			
<b>Position:</b>		<b>Ward</b>	
<b>Address:</b>			
<b>Telephone:</b>			
<b>Email:</b>			

**Referee 2 (Grade no less than a CNM1)**

Name:			
Position:		Ward	
Address:			
Telephone:			
Email:			

**Referee 3(Grade no less than a CNM1)**

Name:			
Position:		Ward	
Address:			
Telephone:			
Email:			

**BANK DETAILS (AGENCY STAFF ONLY)**

Name:	
Address:	
Phone Number:	
Date of birth:	
An Bord Altranais PIN	
PPS Number	
Do you have a P45 from your previous employer	

Bank Name	
Address	
Sort Code (6 numbers)	
Account Number (8 numbers)	

### PREVIOUS WORK EXPERIENCE

(Please tick the clinical areas you have at least 6 months experience)

Anaesthetics		Mental Health – (Chronic)	
Burns		Midwifery	
Cardiology		Neuro Surgery	
Coronary Care		Obstetrics	
Care of the Elderly		Occupational Health	
Community		Oncology	
Dermatology		ODP	
Detoxatology		Orthopaedics	
Diabetes		Paediatrics	
Elderly Care		Palliative Care	
Elderly Care – EMI		Phlebotomy	
Endocrinology		Plastics	
Endoscopy		Psychiatry	
ENT		Recovery	
Gynaecology		Rehabilitation	
Haematology		Renal	
High Dependency		Renal Dialysis	
Infection Control		Rheumatology	
Infectious Disease		Surgical	
Intensive Care		Theatre	
Learning Disabilities - Children		Urology	
Learning Disabilities - Adults		Vascular Surgery	
Medical			
Mental Health – Acute			

Additional Experience If necessary.	
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## PRE EMPLOYMENT MEDICAL QUESTIONNAIRE

Evidence of Hepatitis B immunity level to be supplied	
Evidence of your Hepatitis B antigen levels	
Evidence of your Hepatitis C antibodies	
BCG Records (if applicable in country of origin)	
Mantoux Testing & chest x- ray where required.	
Immunisation records to include Diphtheria, Tetanus & Polio	
Measles & Mumps Antibodies	
Rubella	
Varicella	

Are you currently (or within the last 12 months) taking any medication prescribed by a medical practitioner or a hospital?

Have you a condition for which you are receiving treatment or been recently discharged?

Do you have any condition or long standing impairment which affects your normal day-to-day activities, e.g. walking, reading, cooking and lifting?

Have you ever been refused life insurance or had your insurance premiums increased as a result of a health issue?

Are you on the waiting list for any medical/surgical procedures?

Do you feel any reasonable adjustments will need to be made to enable you to carry out the duties of the post applied for as described in the job description and employee specification?

Have you ever resigned/retired or been dismissed from work due to ill health?

Within the last 3 years, have you had any illness or injury which has resulted in you having to take more than 14 consecutive days sick leave from work

Please indicate the number of days sick leave you have taken from work over the past 2 years:-

(Please note this information will be cross-referenced with any references)

received)

No of Days: \_\_\_\_\_

<b>Do you feel your health is satisfactory for you to be able to carry out the duties specified in the job description and employee specification of the post applied for and maintain a satisfactory attendance record?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>I would like to discuss a health issue with Occupational Health</b>	<input type="checkbox"/>	<input type="checkbox"/>

Once completed please sign and date the form and send to our Compliance Team for processing. In circumstances where further information/clarification is required this declaration will be passed to TTM's Occupational Health Services who will speak to you in confidence.

The information contained on this form will be strictly confidential within the Compliance and Occupational Health Departments. The information will not be used or disclosed to any other person without your written consent.

You need to be aware that where false or incorrect information has been provided your offer of appointment can be withdrawn or your contract terminated.

## **Self Declaration**

I ..... of .....

### **HEREBY DECLARE that:-**

I have never been arrested for or convicted of any offence or crime (other than an offence under road traffic legislation), either in Ireland or in any other state;

I have never been the subject of a pardon or amnesty or other similar legal action in respect of any offence or crime (other than an offence under road traffic legislation for which a penalty of imprisonment is not enforceable):

I have never unlawfully distributed or sold a controlled substance (drug);

I am not currently nor have I ever been to my knowledge under investigation by the Garda Siochana / Police Force of any state in relation to the commission of a crime (other than an offence under road traffic legislation for which a penalty of imprisonment is not enforceable);

I am not currently nor have I ever been the subject of disciplinary action by any professional or statutory body with responsibility for regulation of nursing or medical professions.

I hereby assure that I have received satisfactory immunisation levels and can provide evidence of some of the following vaccines:

- Hepatitis B antibody level
- Measles
- Mumps antibody level
- Rubella
- Varicella
- BCG
- Hepatitis C

I hereby authorise TTM and/or associated partners to make enquiries, for the purpose of verifying any part of this declaration with An Garda Siochana and/or with the regulatory body of nursing or medical profession of any state. This data will be processed by TTM in accordance with the Data Protection Acts, 1998 and 2003.

**Signed**

**Date**

## **WORKING TIME REGULATIONS (Agency Nurses only)**

The European Union have laid down guidelines for all workers governing the length of the maximum working week, which it is deemed safe to work. The Organisation and Working Time Act 1997 states that the maximum average working week for many employees cannot exceed 48 hours per week over a period of 4 months.

I confirm that I have read and understand the information pertaining to the Working Time act and I understand that I will adhere to same.

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

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

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

## **PROFESSIONAL INDEMNITY INSURANCE (Agency Nurses only)**

As a TTM Agency Nurse you are liable for your own nursing practice and therefore need to have your own Professional Indemnity Insurance.

The Irish Nursing Organisation ([www.ino.ie](http://www.ino.ie)) and SIPTU ([www.siptu.ie](http://www.siptu.ie)) provide this insurance cover to their members.

## CHECK LIST

The following documents are required and must be returned with the completed registration form to the Compliance Department at TTM.

1. Copy of current registration with An Bord Altranais
2. Copy of Garda National Immigration Bureau Card ( where applicable)
3. Copy of passport – Certificate
4. CPR Certificate valid within the last two years
5. Patient Moving and Handling Certificate valid within the last two years
6. Fire Safety certificate ( optional)
7. 2 passport photographs **(Agency Nurses only)**
8. Immunisation certificates (see page 7)
9. Copy of Nursing Qualifications
10. Copy of Union Membership **(Agency Nurses only)**
11. Completed Garda Vetting form
12. Evidence of PPS Number
13. €15 cheque /postal order for Garda Vetting process
14. Copy of current IV Policy Certificate certified.