ACN HEALTH CARE

CANDIDATE REGISTRATION PACK

Thank you for choosing to work with us at ACN HEALTH CARE

We pride ourselves on providing a level of service and professionalism appropriate to our position as leading specialists in the Health and Social Care sectors. Moreover, ACN Health Care Ltd enjoys close working arrangements with major client trusts/frameworks to ensure continuity of care and health within our community.

Please take the time to complete the attached document fully so that we may ensure smooth processing of your registration. Should you have any questions please do not hesitate to contact us for clarification.

Completing this application will be deemed to be registering for work with all or any of our companies operating in the Healthcare or Social Care sectors.

ACN HEALTH CARE Ltd is committed to a policy of equal opportunities for all work seekers, adheres to such policy at all times and reviews on a continual basis all aspects of recruitment to avoid unlawful or undesirable discrimination. We treat everyone equally irrespective of gender, sexual orientation, gender reassignment, marital or civil partnership status, age, disability, colour, race, nationality, ethnic or national origin, religion or belief, political beliefs or membership or non-membership of a trade union and we place an obligation upon all staff to respect and act in accordance with the policy.

ACN HEALTH CARE Ltd will not discriminate unlawfully when deciding which candidate/temporary worker is submitted for a vacancy or assignment, or in any terms of employment or terms of engagement for temporary workers. We will ensure that each candidate is assessed fairly in accordance with the candidate's merits, qualification and ability to perform the relevant duties required by the particular vacancy.

Safeguarding privacy and personal data is important to us and in compliance with the General Data Protection Regulations 2018 we would refer you to the bases upon which we may process your data contained within our PRIVACY NOTICE attached.

Note: Please download the ACN Healthcare application form, use Adobe Acrobat reader, any other pdf viewer or web browser to fill in the form, Save it and submit your completed application form, Resume / CV , and any required mandatory certifications documents to: ***info@acnhealthcare.uk***

ACN HEALTH CARE

PERSONAL DETAILS			
Please print your full name as stated on your NMC / HCPC certificate.			
Forename (s):			
Surname:		Surname (if different) on NMC / HCPC Card:	
Title:		Date of Birth:	
Marital Status:		Maiden Name:	
NMC / HCPC Pin (HCPC Reg.) Number:		NMC / HCPC Pin (HCPC Reg.) Expiry Date:	
Current working Band?		Aspiration working Band?	
CURRENT ADDRESS DETAILS			
House number :		Tel. Home:	
Street:		Tel. Work:	
Town / City:		Pager No.:	
County:		Other No.:	
Country:		Postcode:	
Tel. Mobile:			
Email (s):			
NATIONALITY AND ELIGIBILITY TO WORK IN THE UK			
Do you hold a British Passport?		Passport Number:	
Are you an EU Citizen?		Passport Expiry Date: (Please include photocopy)	
Please confirm Nationality, and for non EU Nurses, please confirm your eligibility to work in the UK as a Nurse (Please provide supporting documentation).			

WORK REQUIREMENTS & AVAILABILITY			
Available From:		How many ACN Health shifts per week:	
Specialist Area(s) of Interest:		Other banks / agencies you are registered with:	
Please provide further information regarding your availability (e.g. interest in a new permanent post).			
Please state your geographical preference in relation to location of work. Are you prepared to travel / stay away from home?			

WORK REQUIREMENTS & AVAILABILITY Cont'd	
Please provide us with your nearest underground / railway stations / bus routes:	
Do you have your own transport?	
Please list any computer systems with which you are familiar (e.g. Consult & Prescribe from).	

NEXT OF KIN			
Name:		Relationship:	
House Number:		Tel. Home:	
Street:		Tel. Mobile:	
Town:		Please indicate any special contact details:	
County:			
Country:			
Postcode:			

EMERGENCY CONTACT (IF THE SAME AS ABOVE, PLEASE INDICATE THIS)			
Name:		Relationship:	
House Number:		Tel. Home:	
Street:		Tel. Mobile:	
Town:		Please indicate any special contact details:	
County:			
Country:			
Postcode:			

ACN HEALTH CARE

APPRAISAL AND REVALIDATION DECLARATION – Please sign and date relevant section		
I have had an appraisal in the past year	Name of Appraiser - Date of Appraisal -	**Sign and Date**
I have not had an appraisal in the past year		**Sign and Date**
Revalidation Date	Date of Last Revalidation-	Next Revalidation Due Date –

PROFESSIONAL QUALIFICATIONS, MEMBERSHIPS AND TRAINING			
Date Nurse / ODP / Midwife training started:		Date Nurse / ODP / Midwife training completed:	
Establishment attended:		For student's, date to be completed:	
RCN Membership No.: (if applicable).		Indemnity Provider: (Please provide p/copy of certificate).	
RN Adult, or Children or MH or LD or Asst Prac:		Other Clinical Areas:	
Languages you are fluent in:		CPHVA (Unite) Membership No. (if applicable):	
List all professional qualifications and training courses attended. Continue on a separate sheet if necessary. Please provide photocopies of all certificates. (For convenience, and where appropriate, please state; please see CV).			
Qualification / Training	Institution / Venue	From (Month / Year)	To (Month / Year)

EMPLOYMENT HISTORY			
Please list the last 5 years of your employment, starting with your most recent / current employer. Please explain any gaps in your employment (over 3 months) in the space provided. Please continue on a separate sheet if necessary.			
Employer Contact & Tel. No.:	Position Held:	Date From:	Date To:
Gaps in employment (over 3 months) (please use spare sheets if required):			

PERSONAL DETAILS & MEDICAL HISTORY			
Surname:		Forename (s):	
Date of Birth:		National Insurance No.:	
Title:		Gender:	
Height:		Weight:	
When did you last consult a Doctor?			
Number of days off work due to sickness in last year?			

Please answer all of the following questions. Have you ever suffered from any disorders relating to the following:	YES	NO
1) Cardiovascular system including hypertension?		
2) Blood disorders?		
3) Respiratory System?		
4) Gastrointestinal system, including hepatitis?		
5) Urogenital system, including hernia?		
6) Central nervous system, including fits, headaches and blackouts?		
7) Eyesight, including visual acuity and colour blindness?		
8) Hearing?		
9) Peripheral Nervous system?		
10) Musculoskeletal system, including arthritis?		
11) Back or joint pain?		
12) Upper limb and neck pain?		
13) Psychiatric and psychological conditions, including stress related illness?		
14) Endocrine including, thyroid and diabetes?		
15) Skin including breast disease, including reactions to gloves/powder?		
16) MRSA Carrier? Are you aware of MRSA guidelines and the need for screening?		
17) Allergies?		
18) Any operations / investigations (including future planned procedures) in the last 24 months?		
19) Any accidents, which have significantly affected you physically or mentally?		
20) Are you at present taking or receiving any form of medication? (drugs name and dosage)		
21) Are you HIV positive or at increased risk? (If yes, please confirm below that you aware of the NHS guidelines and that you are willing to comply with them)		
22) A cough for greater than 3 weeks, fever or unexpected weight loss?		
23) A drug or alcohol problem?		
24) Would you regard yourself as having a disability?		
25) Are you pregnant?		
26) Is there any aspect of your medical history an employer should know?		
27) Do you have any impairment which may affect your ability to work safely?		

If you have answered YES to any question above, or you are unsure about any question, please give details below (please use spare sheets if required):.

Occupational Health - Evidence of Immunisation against(tick any applicable):			
Measles		Tuberculosis	
Mumps		Hepatitis B	
Rubella		Hepatitis C (for exposure prone procedures)	
Varicella		HIV (for exposure prone procedures)	

PROFESSIONAL REFEREES			
Please supply two clinical referees, both senior to you in band. Save exceptional circumstances, one referee must be your current or most recent line manager / employer. Please note all referees must be Band 6 and above. Band 5 referees will not be considered but will be accepted as referees for Health Care Assistant. To aid registration, we prefer to hold references prior to arranging your interview. Please contact the Recruitment Team on 0800 800 with any queries regarding your referees.			
Name:		Name:	
Title:		Title:	
Address:		Address:	
Postcode:		Postcode:	
Tel:		Tel:	
Mobile:		Mobile:	
Email:		Email:	
Capacity Known:		Capacity Known:	
Start Date:		Start Date:	
End Date:		End Date:	
Can we contact your referees immediately? (Please tick accordingly)		YES	NO

DECLARATION OF PROFESSIONAL & CONDUCT CRIMINAL RECORD			
Have you been a) removed from the NMC/HPC register b) conditions on your registration c) procedures pending?	YES	NO	
If yes, you are legally obliged to provide the details below (please continue on spare sheet if required):			

Have you been convicted of a criminal offence, been bound over or cautioned or are you currently the subject of any police investigations? Please tick accordingly.	YES		NO	
If yes, you are legally obliged to provide the details below (please continue on spare sheet if required):				
Do you have a Disclosure & Barring Service (DBS) Certificate? Or updating service. Please tick accordingly.	YES		NO	
Do you give ACN HEALTH CARE LTD permission to check your DBS certificate against the Update Service – please hand sign/initial to confirm	YES		NO	
If yes, please scan and email or forward the original certificate with this application form. We recommend that you do this using recorded delivery. Please note that we will be unable to confirm you for an assignment without this certificate.				

DECLARATION OF PROFESSIONAL STANDING:

I understand that Nurses and Midwives hold a position of responsibility and other people rely on us. As a professional, I am accountable for both my actions and omissions in practice. I will always be able to justify my decisions. I always act lawfully and my answers above regarding professional and criminal conduct are true and correct to the best of my knowledge.

Full Name:		NMC Pin:	
Signature:		Date:	

PERSONAL DETAILS

Forename:		Surname:	
Job Title:		Date of Birth:	
National Insurance No.:		Self Assessment No.: (if applicable)	

BANK / BUILDING SOCIETY DETAILS

Bank / Building Society Name:									
Bank / Building Society Address:									
Postcode:									
Account Holder Name (s):									
Account Number:									

Sort Code:									
Building Society Reference:									

ACN HEALTH CARE are a PAYE employer of locum staff. In order to facilitate individual choice, we do process locum pay via personal service companies and umbrella companies. We understand for peripatetic workers that engaging through such vehicles affords continuity of employment, but our advice is that all workers will be best protected by engaging with us via traditional PAYE. Please note all umbrella companies will be approved subject to passing our initial and ongoing compliance checks. Please note, ACN HEALTH CARE reserve the right to remove an umbrella company from our approved list without notice.

Please sign below to confirm your bank details above are correct thereby enabling us to pay you in the most efficient manner. By signing below you are also confirming that it is your responsibility to inform us of any changes to your bank account details, and to confirm that if you work via an umbrella company, you are personally liable for any incorrect tax payments made by your umbrella company on your behalf. ACN HEALTH CARE cannot indemnify itself against other companies providing fraudulent documents to pass an audit and we must make you aware that some umbrella companies will falsify payslips to appear compliant. If you have any concerns that your take home pay from your umbrella provider is incorrect, please advise your ACN HEALTH CARE Consultant.

SIGNATURE:		***DATE:***	
Name:		***Profession:***	

WORKING TIME DIRECTIVE: WTR 48 HOUR WORKING WEEK OPT – OUT

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. Please sign the declaration below in order that we may lawfully employ you if your hours exceed 48. Please note that by signing this Opt – Out you are not committing to a working week of more than 48 hours, but rather allowing yourself to be offered assignments that could take you over this threshold.

Full Name:		NMC Pin:	
Signature:		Date:	

IMPORTANT INFORMATION

PLEASE SIGN THE DECLARATION ABOVE AND PRINT YOUR NAME TO CONFIRM THE ABOVE INFORMATION IS TRUE AND ACCURATE AND THE PAYMENTS WILL BE PROCESSED TO THE RELEVANT ACCOUNT AND THAT YOUR HOURLY PAY IS FULLY INCLUSIVE OF BOTH THE PENSION CONTRIBUTIONS AND HOLIDAY PAY INCLUDING STATUTORY SICK PAY (SSP) & STATUTORY MATERNITY LEAVE (SMP) IN LINE WITH THE WORKING TIME REGULATIONS 2003. ALSO, AS INDICATED, PLEASE ENTER YOUR NMC NUMBER. TO ENSURE A SMOOTH PAYROLL SERVICE. WE RECOMMEND THAT YOU COMPLETE THIS FORM FULLY AND RETURN WITH YOUR COMPLETED REGISTRATION FORMS.

Required Information				
Have you ever been registered with ACN HealthCare clinical solution before?	YES		NO	
Are you registered with another agency and / or nursing bank supply?	YES		NO	
If yes, please provide further details:				
Agencies in England				

CHECK LIST : DOCUMENTS TO BE COMPLETED & ENCLOSED
Please tick the relevant box when returning your

Required Information			
Completed Registration Form.		Certificates of Professional Qualifications / Memberships / Training / Post reg. Courses:	
Completed Occupational Health Statement (Healthier Business Form):		Basic or Advanced Life Support:	
Current Enhanced Disclosure Check		Passport Photocopy	
CV (with no gaps greater than 3 Months)		Where applicable, confirmation of eligibility to work in UK	
References (Two references to cover the last 3 years of employment.)		NMC Annual Statement of Entry (or HPC equivalent)	
NMC Original Statement of Entry		Signed professional indemnity acknowledgement	
Evidence of Professional Indemnity Cover (reqd. for all work outside the NHS)		Copies of appraisal reviews from recent employers.	
Police Check from country of origin (if in UK for less than 6 months)		IELTS Certificate (where applicable).	
Signed ACN HealthCare Terms of engagement and DATA PROTECTION (GDPR) CONSENT FORM		2 Passport sized Photographs: (please email or post)	

Training Certificates - Where required, Please speak to your Compliance Officer on 0800 8000 with your specific training enquiries.

DECLARATIONS
I acknowledge that I have been given a copy of the terms and conditions of service issued by ACN HEALTH CARE LTD & all group brands, which are mine to keep and, furthermore, that I have read those terms and conditions and agree to abide by them.
I accept that in the event of my being engaged with the Company, I will be liable to disciplinary proceedings if it is subsequently shown that medical information was not disclosed to the Company, or has been misleading or false.
I acknowledge that ACN HEALTH CARE LTD has made me aware of the limits of indemnity available under the Clinical Negligence Scheme for Trusts (CNST), and that this cover may not be sufficient to cover all the situations I find myself working. ACN HEALTH CARE LTD have advised me of the importance of taking out my own personal professional indemnity insurance and I realize without this insurance I could be liable for all costs relating to any claim against me.
I declare that all the foregoing statements are correct and true to the best of my knowledge and belief. I confirm I am of sound physical and mental health and accept full responsibility for maintaining my general fitness to practice.

SIGNATURE:		***DATE:***	
PRINT FULL NAME:			

ACN HEALTH CARE - NURSES & MIDWIVES SKILL MATCH Please provide certificates that demonstrate your specialist skills and tick the box denoting your experience. For areas of interest that you have not currently worked in, please tick the box denoting less than 6 months experience:									
NMC Pin Name:				**NMC Pin No:**					
Tell the ACN Recruitment Team about your qualifications so that ACN can accurately match you with our available assignments (please tick where appropriate):									
EN/RN7	☐	ENG/RN2	☐	ENM/ENMH/RN4	☐	LPE	☐	ODP	☐
RFHN	☐	RFN/RN9	☐	RGN/RNI/RNA	☐	RHV/HV	☐	RM	☐
RMN/RN3/RNMH	☐	RN6	☐	RNLD/RN5	☐	ROH	☐	RPHN	☐
RSCN/RN8/RNC	☐	RSN	☐	SCLD	☐	SCMH	☐	SPA	☐
SPC	☐	SPCC	☐	SPCLD	☐	SPCMH	☐	SPDN	☐
SPGP	☐	SPLD	☐	SPMH	☐	TCH	☐	V100	☐
V150	☐	V200	☐	V300	☐	ODA	☐	Practice Nurse	☐
Tell the ACN Health Care Recruitment Team about your training, experience and skills. In line with your NMC Code, please remember you will be held professional accountable for any incorrect statements (please tick where appropriate):									

ACN HEALTH CARE

Specialism	< 6 months	6 months to 1 Year	1 to 2 Years	2 to 3 Years	3 to 5 Years	5 Years +	Specialism	< 6 months	6 months to 1 Year	1 to 2 Years	2 to 3 Years	3 to 5 Years	5 Years +
A&E Trained	☐	☐	☐	☐	☐	☐	IV	☐	☐	☐	☐	☐	☐
A&E Experienced	☐	☐	☐	☐	☐	☐	Learning Disability	☐	☐	☐	☐	☐	☐
Anaesthetic Trained	☐	☐	☐	☐	☐	☐	MAPA trained	☐	☐	☐	☐	☐	☐
Anaesthetic Experienced	☐	☐	☐	☐	☐	☐	Maybo trained	☐	☐	☐	☐	☐	☐
Antenatal	☐	☐	☐	☐	☐	☐	Medical	☐	☐	☐	☐	☐	☐
Baby Immunisations	☐	☐	☐	☐	☐	☐	MAU/PAU	☐	☐	☐	☐	☐	☐
Bereavement Clinic	☐	☐	☐	☐	☐	☐	Mental Health	☐	☐	☐	☐	☐	☐
Blood Pressure	☐	☐	☐	☐	☐	☐	Mental Capacity Trained	☐	☐	☐	☐	☐	☐
Boots MDS System	☐	☐	☐	☐	☐	☐	Minor Injuries	☐	☐	☐	☐	☐	☐
Cardiac	☐	☐	☐	☐	☐	☐	Minor Surgery	☐	☐	☐	☐	☐	☐
Cardiothoracic	☐	☐	☐	☐	☐	☐	Neonatal	☐	☐	☐	☐	☐	☐
Care of the Elderly	☐	☐	☐	☐	☐	☐	Neurology	☐	☐	☐	☐	☐	☐
Challenging Behaviour	☐	☐	☐	☐	☐	☐	Nurse Led Asthma clinic	☐	☐	☐	☐	☐	☐
Chemotherapy	☐	☐	☐	☐	☐	☐	Nurse led cervical smears/cytology	☐	☐	☐	☐	☐	☐
Chronic Disease Management	☐	☐	☐	☐	☐	☐	Nurse led diabetes	☐	☐	☐	☐	☐	☐
City & Guilds 752 ODP	☐	☐	☐	☐	☐	☐	Nurse Practitioner RCN Accreditation	☐	☐	☐	☐	☐	☐
Coil Checks	☐	☐	☐	☐	☐	☐	Nurse Prescribing	☐	☐	☐	☐	☐	☐
Community Nursing	☐	☐	☐	☐	☐	☐	Nursing Homes	☐	☐	☐	☐	☐	☐
Control and Restraint (NHS)	☐	☐	☐	☐	☐	☐	NVQ3	☐	☐	☐	☐	☐	☐
Control and Restraint (private)	☐	☐	☐	☐	☐	☐	NVQ3 ODP	☐	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐	☐	NVQ4	☐	☐	☐	☐	☐	☐
Cosmetic Surgery	☐	☐	☐	☐	☐	☐	Occ. Health Trained	☐	☐	☐	☐	☐	☐
CSSD	☐	☐	☐	☐	☐	☐	Occ. Health Experienced	☐	☐	☐	☐	☐	☐
Day Care Centre	☐	☐	☐	☐	☐	☐	Ophthalmology	☐	☐	☐	☐	☐	☐
Day Surgery	☐	☐	☐	☐	☐	☐	Orthopaedics	☐	☐	☐	☐	☐	☐
Dental	☐	☐	☐	☐	☐	☐	Out patients	☐	☐	☐	☐	☐	☐
Dermatology	☐	☐	☐	☐	☐	☐	Paediatric	☐	☐	☐	☐	☐	☐
Dialysis	☐	☐	☐	☐	☐	☐	PAED ICU Trained	☐	☐	☐	☐	☐	☐
District Nursing	☐	☐	☐	☐	☐	☐	PAED ICU Experienced	☐	☐	☐	☐	☐	☐
DOLS trained	☐	☐	☐	☐	☐	☐	Palliative Care	☐	☐	☐	☐	☐	☐
Dressings	☐	☐	☐	☐	☐	☐	Personal safety trained	☐	☐	☐	☐	☐	☐
Ear Syringing	☐	☐	☐	☐	☐	☐	Phlebotomy / Venupuncture	☐	☐	☐	☐	☐	☐
Eating disorders	☐	☐	☐	☐	☐	☐	PMVA trained	☐	☐	☐	☐	☐	☐
ECGs	☐	☐	☐	☐	☐	☐	Practice Nurse experience	☐	☐	☐	☐	☐	☐
Emergency Nurse Practitioner (ENP)	☐	☐	☐	☐	☐	☐	Prisons	☐	☐	☐	☐	☐	☐
ENB Practice Nurse Certificate	☐	☐	☐	☐	☐	☐	PSTS awareness trained	☐	☐	☐	☐	☐	☐
Family Planning Practice Nurse	☐	☐	☐	☐	☐	☐	Radiology	☐	☐	☐	☐	☐	☐
Family Planning	☐	☐	☐	☐	☐	☐	Recovery	☐	☐	☐	☐	☐	☐
Flu Vaccinations	☐	☐	☐	☐	☐	☐	Renal	☐	☐	☐	☐	☐	☐
Gastrostomy	☐	☐	☐	☐	☐	☐	Residential Homes	☐	☐	☐	☐	☐	☐
GU Med	☐	☐	☐	☐	☐	☐	RMA	☐	☐	☐	☐	☐	☐
Gynaecology	☐	☐	☐	☐	☐	☐	SCBU trained	☐	☐	☐	☐	☐	☐
Haematology	☐	☐	☐	☐	☐	☐	SCBU experienced	☐	☐	☐	☐	☐	☐
Health Promotions	☐	☐	☐	☐	☐	☐	School Nurse	☐	☐	☐	☐	☐	☐
Health Visitors	☐	☐	☐	☐	☐	☐	Scrub	☐	☐	☐	☐	☐	☐

HDU Trained							Smoking cessation							
High Vaginal Swabs							Spirometry							
Home Care							Stoma Care							
Hospices							Surgical							
Hospitals							Termination Clinic							
In Charge Duties							Theatre							
Injections							Tracheostomy							
ICU Trained							Travel clinic							
ICU Experienced							Travel Immunisations							
ICU Neonatal							Treatment Room							
ICU Psychiatric							Urology							
IDTS							Vascular Surgery							
IDTS							Ventilator							
IT Skills							Well man clinic							
ITU trained							Well woman clinic							
ITU experienced							Other							

Where applicable, please provide details of your "other" training, experience and / or competency:

ACN HealthCare Recruitment Team – for office only:	**Date Received:**		**Date Processed:**		**EN Rating**		**Loaders Initials:**

ACN HEALTH CARE– We Care *(policy available upon request).*

For the purpose of promoting a corporate commitment to equality and diversity, we kindly ask that you complete the following optional questionnaire:

Your Age & Gender

Prefer not to say

Age	16-24		25-34		35-44		45-54		55-64		65-74		75+	

Gender	Male		Female		**Gender Identity:**	Transsexual		Transgender		Intersex	

Your Ethnic Origin

Prefer not to say

White		British		Irish		Other	
Black		African		Caribbean		Other	

Asian		Bangladeshi		Indian		Pakistani		Other	
Mixed		White & Black Carribean		White and Black African		White and Asian		Other Mixed	

Do you consider yourself to have a disability within the meaning of the Equality Act 2010?	Yes:		No:		Prefer not to say:	

Your Religion and Belief

Prefer not to say

Agnostic		Bahai		Buddhist		Catholic		Christian		Hindu	
Jain		Jewish		No Religion		Other		Protestant		Sikh	

Your Sexual Orientation

Prefer not to say

Bisexual		Homosexual woman		Homosexual man		Heterosexual	

ADDRESS: 22 Barley Court, Colchester Road

Wivenhoe, Colchester, Essex CO7 9HS

Tel no: +44 7532 309683

Email: info@acnhealthcare.uk

Website: https://www.acnhealthcare.uk

ACN HEALTH CARE

Company Name:	ACN HEALTH CARE LTD
Document DP6:	Consent declaration
Topic:	Data protection
Date:	
Version:	1

I hereby consent to the Company processing the above personal data for the following purposes:

- For the Company to provide me with work-finding services.
- For the Company to process with or transfer my personal data to their clients in order to provide me with work-finding services.
- For the Company to process my data on a computerised database provided by Matchmaker in order to provide me with work-finding services.
- For the Company to process payroll via its outsourced payroll service providers
- For the Company to provide training services
- For the Company to provide accommodation finding services

I also consent to the Company processing my personal data with third parties including Framework Providers and Master Vendors for the purposes of internal audits and investigations carried out on the Company to ensure that the Company is complying with all relevant laws and obligations.

The consent I give to the Company will last for two years.

I am aware that I have the right to withdraw my consent at any time by informing the Company that I wish to do so.

I understand the Company may also rely on other lawful bases for processing personal data vis: Legitimate Interest, Legal Obligation, or Contractual Obligation as defined in our PRIVACY NOTICE attached.

Name (Please print) : _____

Signature: _____

Date: _____

Note: Please download the ACN Healthcare application form, use Adobe Acrobat reader, any other pdf viewer or web browser to fill in the form, Save it and submit your completed application form, Resume / CV , and any required mandatory certifications documents to: **info@acnhealthcare.uk**

Click Here To Submit