



VICTORIAN NURSE SPECIALISTS
 Suite 3, 107 Union Road, Surrey Hills ~ PO Box 198 Surrey Hills 3127
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ABN 96 094 751 130

Personal Details

Surname:	Address:
Given name:	Suburb: Post code:
Date Of Birth:	Postal Address:
Email:	Suburb: Post code:
Phone number:	Drivers licence number:
Mobile number:	Practising certificate number:
Hobbies/Interests:	

Next of Kin Details

Surname:	Address:
Given name:	Suburb: Post code:
Contact number:	Relationship:

Nurse Classification:

<input type="checkbox"/> Registered Nurse Division 1:	<input type="checkbox"/> Personal Care Attendant:
<input type="checkbox"/> Registered Nurse Division 2:	<input type="checkbox"/> Patient Services Assistant: / <input type="checkbox"/> Ward Support:
<input type="checkbox"/> Registered Nurse Division 3:	<input type="checkbox"/> Orderly: - <input type="checkbox"/> Wards <input type="checkbox"/> Theatre <input type="checkbox"/> Other
<input type="checkbox"/> Registered Nurse Aged Care:	<input type="checkbox"/> Instrument Technician:
<input type="checkbox"/> Theatre Technician:	<input type="checkbox"/> Other:

Please indicate all the post basic qualification(s) you hold:

<input type="checkbox"/> Emergency Department	<input type="checkbox"/> Critical Care / Intensive Care	<input type="checkbox"/> Neonatal Intensive Care	<input type="checkbox"/> Paediatric Intensive Care
<input type="checkbox"/> Cardiothoracic	<input type="checkbox"/> Education	<input type="checkbox"/> Neuro / Neurosurgery	<input type="checkbox"/> Peri operative
<input type="checkbox"/> Maternal & Child Health	<input type="checkbox"/> Geriatric / Gerontology	<input type="checkbox"/> Oncology	<input type="checkbox"/> Renal / Dialysis
<input type="checkbox"/> Community Health	<input type="checkbox"/> Mental Health / Psychiatric	<input type="checkbox"/> Orthopaedic	<input type="checkbox"/> Workplace Assessment
<input type="checkbox"/> Coronary Care	<input type="checkbox"/> Midwifery	<input type="checkbox"/> Paediatric	<input type="checkbox"/> Other

Training Institution: Training Completed: (dates)

Please indicate your Clinical Preferences:

<input type="checkbox"/> A & E	<input type="checkbox"/> Clinical Education	<input type="checkbox"/> Oncology	<input type="checkbox"/> Scrub / Scout
<input type="checkbox"/> Aged Care	<input type="checkbox"/> Coronary Care	<input type="checkbox"/> Orthopaedic	<input type="checkbox"/> Midwifery
<input type="checkbox"/> Anaesthetics	<input type="checkbox"/> General Medical	<input type="checkbox"/> P.A.C.U.	<input type="checkbox"/>
<input type="checkbox"/> Cardiothoracic	<input type="checkbox"/> General Surgical	<input type="checkbox"/> Paediatrics	<input type="checkbox"/>
<input type="checkbox"/> Cardio	<input type="checkbox"/> Intensive Care	<input type="checkbox"/> Recovery	<input type="checkbox"/> Other

Past Employment

Date from:	Date to:	Place / Position / Area of Duty:

How did you find out about VNS?	
<input type="checkbox"/> VNS Nurse – Name:	<input type="checkbox"/> Promotional Products – Specify:
<input type="checkbox"/> Friend <input type="checkbox"/> Colleague referral	<input type="checkbox"/> Newspaper – The Age / Herald Sun (circle)
<input type="checkbox"/> Hospital – Specify:	<input type="checkbox"/> Yellow Pages
<input type="checkbox"/> Internet – Job search - Search Engine:	<input type="checkbox"/> Other:

Medical Conditions

Do you have any pre-existing medical conditions including injuries or diseases that will affect the nature of your employment? If Yes please provide details.

YES: _____

NO: _____

Annual Competencies

<input type="checkbox"/> CPR – Date:	<input type="checkbox"/> Infection Control – Date:
<input type="checkbox"/> No Lift – Date:	<input type="checkbox"/> Fire Safety – Date:
<input type="checkbox"/> Medication Calculations – Date:	<input type="checkbox"/> Other – Date:
Comments: _____	<input type="checkbox"/> Given On-Line Competency Info.
_____	Due: _____

Immunisation Status

MMR – Date/s: _____ Chicken Pox _____ Date/s: _____

Hepatitis B – Date/s: _____ Flu Vax _____ Date/s: _____

Tetanus – Date/s: _____

Tuberculosis – Date: _____ Reading: _____

Professional References

Reference 1:	Name:	Contact number:
	Position:	
Reference 2:	Name:	Contact number:
	Position:	

Bank Account Details

Account Name:	_____		
Bank:	_____		
BSB Number:	_____	Account Number:	_____
Email Payslips:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Email Address:	_____

Sub-section (8) of the Accident Compensation Act 1985 will apply to a failure to make a disclosure or the making of a false or misleading disclosure.

I acknowledge that I have read and understood the Agency guidelines and the Agency Agreement, and declare all information I provide to the agency to be true and correct.

Nurses Signature:	Date:	Signed for and on behalf of Victorian Nurse Specialists:	Date:
_____	_____	_____	_____

References Checked <input type="checkbox"/>	Induction Guide <input type="checkbox"/>
Computer Master File <input type="checkbox"/>	O H & S Policy <input type="checkbox"/>
Police Check Sent <input type="checkbox"/>	Job Description <input type="checkbox"/>
Super Choice Form <input type="checkbox"/>	ID Badge Issued <input type="checkbox"/>
Enrolment Fee <input type="checkbox"/>	TFN Form <input type="checkbox"/>
Specialty Rate: Yes <input type="checkbox"/>	No <input type="checkbox"/>
RNA <input type="checkbox"/>	RNC <input type="checkbox"/>
Discusses at interview <input type="checkbox"/>	RNAT <input type="checkbox"/>
	RNCT <input type="checkbox"/>
	4A <input type="checkbox"/>
	5A <input type="checkbox"/>
	Other <input type="checkbox"/>
Category - Registered Nurse Division 1 <input type="checkbox"/> Division 2 <input type="checkbox"/> Other <input type="checkbox"/> _____	
Grade _____ Year _____ (to be recorded on computer master file)	
Initials _____ Date _____	