FORWARD ACADEMIC TEAM
DIPLOMA IN DENTAL NURSING COURSE
Student Application Form

PERSONAL DETAILS		Please affix your recent passport size photograph
Mr/Mrs/Ms	**Male/Female**	
First Name	**Surname**	
Date of Birth	**Nationality**	
Address:		
Post Code	**Email:**	
Next of Kin (in case of emergency)		
Do you hold a working Visa	**Expiry Date**	
Home tel:	**Mobile tel:**	
Insurance Number		

QUALIFICATIONS			
Please include any subject that you are studying including past courses			
Institution	**Qualification**	**Result/Grade**	**Date qualified**

YOUR REQUIREMENTS
Do you think you need extra English Language support during our course? Yes( ) No ( )
Do you need a placement to start work? Yes ( ) No ( )
How do you propose to get to the course? By public transport ( ) by Car ( )
What location would you prefer to work in:
Why do you wish to do this course?

WORK HISTORY

Employer	Dates	Grade	Pay Rate	Post

If you do not have a CV and require more space, please attach additional sheet to the back of this form.

MEDICAL QUESTIONNAIRE

How many sick days have you had in the last 12 months? Please give reasons and duration

Most Recent Chest X Ray

Date	Result
1)	
2)	

Do you currently smoke	**Yes ( ) No ( )**
If yes how many do you smoke a day	**Less than 5 Between 5020 Over 20**
Do you drink Alcohol?	**Yes ( ) No ( )**
If yes, what amount daily	
What is you height?	
What is your weight?	**St Ib**

Do you currently, or have you in the past suffered from any disorders relating to the following symptoms?

Respiratory (including asthma, pneumonia, breathlessness or allergies	**Yes**	**No**
Cardiovascular (including high blood pressure or chest pains	**Yes**	**No**
Gastrointestinal (including dysentery, typhoid or any gastric ailment	**Yes**	**No**
Central Nervous (including Headaches, migrant, fits or epilepsy	**Yes**	**No**
Genito Urinary (including any kidney or bladder infections)	**Yes**	**No**
Dermatological (including eczema, dermatitis or any skin infection	**Yes**	**No**
Endocrinology (including diabetes, thyroid or gland disorder	**Yes**	**No**
Haematological (including low red blood cell count)	**Yes**	**No**
Locomotors (including rheumatoid arthritis prolonged backache, disc trouble	**Yes**	**No**
Have you any known allergies	**Yes**	**No**
Have you ever taken an overdose of drugs?	**Yes**	**No**
Do you have a history of mental illness?	**Yes**	**No**
Do you have a medical condition affecting sleep?	**Yes**	**No**
Is there any medical reason why you could not work at night	**Yes**	**No**
Are you pregnant	**Yes**	**No**
Have you ever been treated for abuse or addiction to any substances	**Yes**	**No**
Are you currently under medical supervision or taking any medication	**Yes**	**No**

If yes please give details below:

YOUR VACCINATION RECORD			
What following vaccination have you had in the past 10 years			
Hepatitis B **(If yes, when is your booster due)**			
Tuberculosis (BCG)			
Positive Heaf Test			
Tetanus			
Rubella Screening Test			
Oral Polio			
Typhoid			
Diphtheria			
Chicken Pox			
Please provide documentary evidence (a copy of original certification) or a Letter from your GP together with this application form. **Hospitals in the UK may not employ healthcare workers unless they are able to produce documentary evidence of Hepatitis B status.**			

Do you have a criminal record? **Yes** **No**

Have you had a DBS (Disclosure & Barring Service) check carried out? **Yes** **No**

If yes, Please provide the DBS Certificate number ………………………… and date of issue…………………………..

CONTINUED PROFESSIONAL DEVELOPMENT TRAINING (if applicable)		
Please list below details of any relevant courses completed (please enclose copy certificate)		
COURSE NAME	**LOCATION**	**DATE**

TRAINING DETAILS		
Health and Details		
Have you completed an approved lifting/manual handling programme	**Yes**	**No**
Have you completed a course in Basic Cardiopulmonary Resuscitation	**Yes**	**No**
Have you completed a course in control and Restrain Techniques	**Yes**	**No**

YOUR REFEREES	
FAT will only contact you referees once we have your permission **Please give the names and addresses of you r referees** **Once referee should be your current or last employer**	
Name: **Address:** **Tel:** **Fax:** **Email**	**Name:** **Address:** **Tel:** **Fax:** **Email**

How did you hear about Forward Academic Team ?

Please tick the most appropriate

Internet	Leaflet	Friend	Other (Please specify)

Please sign and confirm that the information you have supplied is correct and you will notify FAT of any relevant changes.

…………………………….   ……………………………   …………………

Print Name   **Signature**   **Date**