

**Nurse Registration Form**

Tel: 01522 561560  
Fax: 0870 7627131  
mail@principlemedical.co.uk

This form should be completed by all nurses who wish to undertake medical examinations for Principle Medical Services Limited.

Please complete in full and return to the Chief Medical Officer at the above address by post/fax or email.

Nurse based medicals are predominantly carried out at the clients home or occasionally at the place of work.

All details will be held confidentially by Principle Medical Services and not shared for commercial or other reasons with any third party. Principle Medical Services is registered under the Data Protection Act.

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

Qualifications: \_\_\_\_\_

UKCC pin number: \_\_\_\_\_

Mobile telephone number: \_\_\_\_\_

Home telephone number \_\_\_\_\_

Email address: \_\_\_\_\_

Home address : \_\_\_\_\_

Town: \_\_\_\_\_ p/code \_\_\_\_\_

No. of years in Profession: \_\_\_\_\_ years

Please list any specialities you may have. i.e. Occupational Health, Case Management

\_\_\_\_\_

Are you a member of a union or professional organisation offering Indemnity Insurance      Yes       No

Do you carry out this type of work for other agencies?      Yes       No

Please list agencies. *This is not obligatory and we will NOT contact any agencies.*

\_\_\_\_\_

**Do you have daily use of the following equipment:**

Sphygmomanometer:	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Tape Measure:	yes	<input type="checkbox"/>	no	<input type="checkbox"/>		
Stethoscope	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	Peak flow meter	yes	<input type="checkbox"/>	no	<input type="checkbox"/>		
Cuffs	small	<input type="checkbox"/>	med	<input type="checkbox"/>	large	<input type="checkbox"/>	Weighing scales*	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

Do you have access to the web?	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Do you access to e-mail?	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Do you have access to a mobile phone?	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Do you have access to a fax machine?	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Do you have access to a scanner?	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Are you willing to take saliva swabs? (Oral fluid testing)	yes	<input type="checkbox"/>	no	<input type="checkbox"/>
Are you able to take blood samples?	yes	<input type="checkbox"/>	no	<input type="checkbox"/>

**Availability to undertake medicals:**

Please indicate how many medicals you would like to carry out: *(the number you indicate may not be the number you will actually receive)*

**Weekly**

up to 5            up to 10            more than ten (please indicate)     

So we do not send you medicals that are too far away, we would be grateful if you could indicate a general area in which you could cover. The first part of the postcode would be ideal; but towns and areas will suffice. A mileage area from your home will also suffice. i.e. 20 mile radius!

---



---



---

*\*Scales should be able to measure up to 22 or 24 stone*