



APPLICATION FOR PART/FULL-TIME/LOCUM WORK

- Complete all questions on the application form using a black pen.
- All information will be regarded as strictly confidential.
- Any outstanding documents or information i.e. Income tax number SSNIT, proof of professional certificate or document which will result delay with future payments.

Registration requirements: Copies of the following documents are required to ensure registration with comfort medical service:

◇ Identity document	
◇ Ghana Nursing and midwifering council certificate	
◇ National Vocational Training Institute certificate	
◇ Others	

1. PERSONAL INFORMATION																																																																																																					
<p>Surname: _____</p> <p>Initials: _____ Title: _____</p> <p>Date of Birth: <table border="1" style="display: inline-table; text-align: center; width: 150px; height: 20px;"><tr><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>-</td><td>M</td><td>M</td><td>-</td><td>D</td><td>D</td></tr></table></p> <p>Gender: <table border="1" style="display: inline-table; text-align: center; width: 100px; height: 20px;"><tr><td>Male</td><td>Female</td></tr></table></p> <p>Marital Status: <table border="1" style="display: inline-table; text-align: center; width: 150px; height: 30px;"><tr><td>Single:</td><td>Separated:</td></tr><tr><td>Married:</td><td>Widowed:</td></tr><tr><td>Divorced:</td><td></td></tr></table></p> <p>Next of kin: _____</p> <p>Contact number: <table border="1" style="display: inline-table; text-align: center; width: 100px; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table></p>	Y	Y	Y	Y	-	M	M	-	D	D	Male	Female	Single:	Separated:	Married:	Widowed:	Divorced:												<p>First Names: _____</p> <p>Nationality: _____</p> <p>Disabled: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Mode of Transport: <table border="1" style="display: inline-table; text-align: center; width: 100px; height: 20px;"><tr><td>Public</td><td>Private</td></tr></table></p> <p>Home Language: _____</p>	Public	Private																																																																						
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2. PROFESSIONAL INFORMATION:

Nursing

Registered Nurse	
Enrolled Nurse	
Health Care Assistant	
Health Care worker	

Professional Number:	

Medical doctor
Physiotherapist
Radiographer
Pharmacist
BioMedical Scientist

Additional qualifications :

Qualification:(Degree/Diploma)	Date:	Institution	Additional course	Date:	Institution
Physician assistant			ACLS		
Emergency Nursing			Sonography		
Urology Nursing			BLS		
ENT Nurse			Telemetry/ECG		
Nurse Anaesthetist			Phlebotomist		
Psychiatric Nurse			HIV Counsellor		
Midwifery			Other:		
Occupational Nurse					
Oncology					

3. WORKING EXPERIENCE

DISCIPLINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NAME OF HOSPITAL	FROM-TO
PHARMACY	Adult	Paediatric	Neonatal		Period
TRAUMA					Period
HIGH CARE	Adult	Paediatric	Neonatal		Period
THEATRE	Scrub nurse	LABOUR	Anaesthetic		Period
WARDS	Maternity	Post natal	Orthopaedic		Period
	Paediatric	Surgical	Medical		Period
	Oncology	Psychiatry	Emergency		Period

4. EMPLOYMENT STATUS – Declaration of Income

I, _____ Identity number: _____

(Full name & surname)

hereby declare that (Please mark the appropriate block):

<input type="checkbox"/>	I am not permanently employed and receive NO other source of income. CHA is my ONLY source of income. Tax deduction will be according to GRA\SSNIT guidelines (Tax tables: Daily, weekly, monthly)
<input type="checkbox"/>	I am currently permanently employed by: _____ Tax deduction for secondary income through CHA will be deducted
<input type="checkbox"/>	I am also registered through institution and CHA will be my secondary source of income and therefore my tax deduction will be through CHA

I will notify COMPANION HEALTHCARE AGENCY immediately should my employment status changes.

PERSONAL INCOME TAX REFERENCE NUMBER:

Visit your nearest GRA office to register as an Income Tax payer. You must ensure that your number is correct.

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Please take note: Each employee is responsible to ensure that their tax deduction from their employer(s) is accurate. Failure to adhere to the rules prescribed by GRA might result in you owing GRA money at the end of the tax season

5. BANKING DETAILS

Name of Bank: _____	Account Number: <table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																					Type of Account: _____
Branch: (where you have opened your account) _____		Account Holder: _____																				

6. PAYMENT FREQUENCY:

DAILY ONLY: Louis Pasteur ZAH-TUESDAYS Medi Clinic	WEEKLY Fridays Netcare,ZAH,Medi Clinic, Louis Pasteur Wednesdays Life,Netcare,Private hosp.	MONTHLY On/before last workday of month
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7. DECLARATION:

7.1 I _____ the under signed, hereby declare that I have approached COMPANION HEALTHCARE AGENCY. to assist me in finding temporary, locum, permanent employment. I further agree that the completion of this registration form does not give rise to reasonable expectation or offered temporary/permanent employment by CHA agency. I understand that any form of misrepresentation can/will lead to this application being declared null and void.

7.2 I hereby declare that I understand the Cancellation policy of the agency and therefore give authorization to CHA per Cancellation policy.

7.4 I declare that the above information supplied by me, is true and correct & I hereby give CHA permission to verify the employment history as completed in this document.

7.5 I _____ herewith confirm that I have received the following documentation from COMPANION HEALTHCARE AGENCY:

	CHA Information document
	Disciplinary Code and Grievance Procedure

I understand that it remains my responsibility to obtain information or to request CHA to explain issues related to this documentation, if unclear to me.

Signed at _____ on this _____ day of _____ 20_____

Employee signature

Witness (on behalf of CHA)

4 Terms and Conditions of Employment

- 4.1 The EMPLOYEE undertakes to perform to the best of his/her abilities the duties, functions and responsibilities normally associated with the position.
- 4.2 The EMPLOYEE agrees to the statutory deduction of NHIS Levy
- 4.4 In addition to the above terms and conditions, the EMPLOYEE agrees to comply with all appropriate and reasonable terms and conditions of the EMPLOYER, that may not specifically be addressed in this contract, including:
 - 4.4.1 Adhere to the Code of Conduct of the EMPLOYER.
 - 4.4.2 Standard Operating and Computer Systems / Electronic Communication Procedures.
 - 4.4.3 Health and Safety procedures.

4.5 Whilst on assignment with a client, you shall:

- 4.5.1 Obey all reasonable instructions issued to you by a representative of the Client, and which fall within your Scope of Practice. Should you perform work outside your Scope of Practice, you do so at your own risk. Furthermore, such conduct may be regarded as a material breach of this contract warranting the summary termination thereof.
 - 4.5.2 Use the assets of the Client entrusted to you with the utmost care.
 - 4.5.3 Demonstrate loyalty, honesty and good faith to the Company in all dealings and transactions relating to its business.
 - 4.5.4 Adhere to the working time arrangements (including the shift systems, meal and tea breaks) that are in place at the Client's premises.
 - 4.5.5 Ensure that you record the hours that you have worked in accordance with the systems in place at the Client. It is the responsibility of the EMPLOYEE to sign the work register at the Client.
 - 4.5.6 Observe and obey all the safety and security rules of the Client and act with due care and diligence towards fellow employees or third parties with whom you have dealings, during the course and scope of your employment.
 - 4.5.7 Consent to your person and/or possessions, including any vehicle over which you exercise control, to be searched by any person appointed by the Client to do so, with regard to compliance with the law.
- 4.6 The EMPLOYEE shall be required to provide own transport arrangements to and from work.
 - 4.7 The EMPLOYEE will be entitled to 4 months unpaid maternity leave and Maternity benefits. The EMPLOYER is not responsible for the payment of any form of Maternity/paternity benefits.
 - 4.9 The EMPLOYEE understands and agrees that confirmation of an assignment by the EMPLOYER, whether in writing or verbal agreement is a binding contractual agreement and failure of the EMPLOYEE to arrive for the assigned shift, without prior notification to the EMPLOYER will result in breach of this agreement

5 Confidentiality

- 5.1 The EMPLOYEE acknowledges and understands that during the course of the assignment, the EMPLOYEE may become familiar with the confidential information of the EMPLOYER and its Clients including commercial and technical secrets and/or other confidential information.
- 5.2 The EMPLOYEE will not at any time disclose or make use of, directly or indirectly any confidential information to any third party or entity during the operation of this agreement or after its termination, unless authorized for a purpose by the EMPLOYER and/or Client.
- 5.3 In the event of uncertainty whether any disclosure is for an authorized purpose, the EMPLOYEE will obtain a ruling in writing from the EMPLOYER and/or Client, as the case may be and is to abide by it.
- 5.4 The EMPLOYEE will return to the EMPLOYER, whenever required to do so, or when leaving the employment of the EMPLOYER, all property concerning or containing any reference to the business of the EMPLOYER or the Client including all books of account, training, development, notes, records and the like.

6 Guarantee of Competency

- 6.1 The EMPLOYER is obliged to ensure at all times that he/she is registered or enrolled as a Professional with the relevant body. Failure to comply with this duty will be regarded as a material breach of this contract, warranting the termination thereof.
- 6.2 The EMPLOYEE guarantees that he/she is competent to carry out the services associated with his/her position under this contract and that he/she is qualified to occupy the position as envisaged herein.
- 6.4 The EMPLOYEE is required to attend the EMPLOYER's training programs from time to time and to be available for clinical facilitation offered by the EMPLOYER and/or Client as and when required.
- 6.5 The EMPLOYEE further declares that there is no medical condition, either physical or psychological of which he/she is aware that would impede his/her performance on an assignment, or hold an actual or potential risk to the health and safety of the EMPLOYEE himself/herself, a fellow employee or a member of the public.

7 Termination

- 7.1 As described in the introduction of this agreement, the LDC will expire automatically upon termination/ resignation and/or dismissal for operational requirements
- 7.2 The EMPLOYER undertakes to provide reasonable notification to the EMPLOYEE of the termination where it is appropriate to do so.

- 7.3 Should the EMPLOYEE become incapacitated or incapable of performing his/her duties as envisaged in this agreement by reason of physical or mental incapacity, your employment with the EMPLOYER will be terminated.
- 7.4 The EMPLOYEE agrees to provide the EMPLOYER with the following written notice of termination of this agreement
- 7.4.1 during the first six months = one week
 - 7.4.2 after six months = two weeks
 - 7.4.3 after one year = four weeks.
- 7.5 The EMPLOYER may terminate your employment summarily, following disciplinary hearing, at any time.

8 Declaration

- 8.1 I understand that I have accepted the above LDC and I will not have an expectation of permanent employment or renewal of the LDC.
- 8.3 I _____ herewith confirm that I have read, understand and accept the terms and conditions contained in the LDC. Furthermore, I also understand that I shall only receive payment for actual hours worked and that a "no-work-no-pay" arrangement will apply if no hours are worked for any reason whatsoever. I further indemnify and hold the EMPLOYER harmless against all losses, damage, costs and expenses which the EMPLOYER may sustain or incur as a result of any conduct or omission by myself in rendering my services to any of the EMPLOYER's clients.

Signed at _____ on this _____ day of _____, 20__.

EMPLOYEE

For and on behalf of : **Companion Healthcare Agency**

As witnesses:

For Companion Healthcare Agency

1. _____

1. _____

2. _____

2. _____



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