



Professional Associate Networking
Expression of Interest

Please complete in handwriting. This information will be held on a computer database and will only be used for the purpose of professional networking. The database will not be accessed by a third party or sold or reproduced for circulation.

Full Name		Title: Ms Miss Mrs Mr Dr	
Address		Date of Birth	
Postcode		Professional registration numbers e.g. NMC PIN/GMC No.	
		First language:	
Home telephone No		Best time for contacting	
Fax No		E-mail address	
Current area of practice: Please ring as appropriate			
Occupational Health Nursing Occupational Medicine Safety Management Occupational Hygiene Ergonomics Fitness & Lifestyle Assessment Other:			
Professional Qualifications:			
Professional Indemnity Insurance:			
Policy Number		Name of Insurer	Expiry date
Current employment status: Please ring as appropriate			
Full-time employment	Part-time employment	Sessional or Project Work	
Self employed	Own business	Not working	

1. What kind of work do you undertake/are you looking for?
2. Are you available for

Long Term Contracts?	<input type="checkbox"/>
Short Term Contracts?	<input type="checkbox"/>
Full Time Work?	<input type="checkbox"/>
Occasional Work?	<input type="checkbox"/>
Sessional Work?	<input type="checkbox"/>

3. Do you like a variety of work such as
Different clients?
Different tasks?
4. Are you willing to travel per round trip from your home
20-50 miles 50-100 miles 100-200 miles ?
5. Are you willing to stay overnight, if required? Yes No
6. Could you travel independently to clients with equipment and files?
Yes No
7. Do you mind a) travelling at night? Yes No
b) to unknown places? Yes No
8. Do you see yourself as a team player? or a team leader?
9. Do you prefer
to follow a pre-arranged routine?
or to create your own work routine?
10. Do you feel confident to provide advice
directly to management
or to report back to Gipping OH Ltd
11. What is your hourly/daily rate? £
12. Would you prefer to be
an Independent (self-employed) Practitioner?
or an Employee?
13. Do you have other working commitments? Yes No
14. How far in advance can you commit yourself to providing service?
2 weeks 6 weeks 2 months 6 months 1 year
15. Will you need to adjust your timetable from time-to-time?
Yes No
If yes, for what sort of reasons?
16. What do you see as your strengths?
17. What do you see as challenge within your personal professional capacity?
18. What benefits do you see in working with a Professional Associate Network?

19. Have you enclosed your Professional Profile? Yes No
If you work independently, please include any promotional material.

20. Do you keep a current Professional Portfolio? Yes No

21. Do you have experience in the following areas:

	Yes	No
Pre-employment health screening	<input type="checkbox"/>	<input type="checkbox"/>
Health assessment	<input type="checkbox"/>	<input type="checkbox"/>
Health Surveillance	<input type="checkbox"/>	<input type="checkbox"/>
Lung Function Assessment	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Assessment	<input type="checkbox"/>	<input type="checkbox"/>
Vision Screening	<input type="checkbox"/>	<input type="checkbox"/>
Assessing Body Mass Index	<input type="checkbox"/>	<input type="checkbox"/>
Urine Analysis	<input type="checkbox"/>	<input type="checkbox"/>
Venepuncture	<input type="checkbox"/>	<input type="checkbox"/>
ECG recording	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure Assessment	<input type="checkbox"/>	<input type="checkbox"/>
Examination of the skin	<input type="checkbox"/>	<input type="checkbox"/>
HAV assessment	<input type="checkbox"/>	<input type="checkbox"/>
Advice on absence monitoring	<input type="checkbox"/>	<input type="checkbox"/>
Accident/incident/illness investigation	<input type="checkbox"/>	<input type="checkbox"/>
Examining/training for First Aid to NVQ standards	<input type="checkbox"/>	<input type="checkbox"/>
Making presentations/providing training	<input type="checkbox"/>	<input type="checkbox"/>
Providing Legal Advice/Expert Witness	<input type="checkbox"/>	<input type="checkbox"/>
Medical Examination	<input type="checkbox"/>	<input type="checkbox"/>
Risk Assessment	<input type="checkbox"/>	<input type="checkbox"/>
Safety Audit/review	<input type="checkbox"/>	<input type="checkbox"/>
Writing Health and Safety Policies	<input type="checkbox"/>	<input type="checkbox"/>
Noise Assessment	<input type="checkbox"/>	<input type="checkbox"/>
Managing or Assessing the Environment	<input type="checkbox"/>	<input type="checkbox"/>
Case discussion with employer	<input type="checkbox"/>	<input type="checkbox"/>

22. Do you have specific area/s of expertise/interest? Yes No
If yes, please give details

23. Do you own, for professional practice, any of the following equipment:

	Yes	No
Sphygmomanometer/Stethoscope	<input type="checkbox"/>	<input type="checkbox"/>
Spirometer for testing lung function & disposable tubes	<input type="checkbox"/>	<input type="checkbox"/>
Weighing scales	<input type="checkbox"/>	<input type="checkbox"/>
Equipment for measuring height	<input type="checkbox"/>	<input type="checkbox"/>
Eye test charts - near, far	<input type="checkbox"/>	<input type="checkbox"/>
Tape measure	<input type="checkbox"/>	<input type="checkbox"/>
Otoscope for ear examination	<input type="checkbox"/>	<input type="checkbox"/>
Ophthalmoscope for eye examination	<input type="checkbox"/>	<input type="checkbox"/>
Urine sample containers and testing strips	<input type="checkbox"/>	<input type="checkbox"/>
PPE - eg Safety shoes, hard hat, goggles, high visibility vest	<input type="checkbox"/>	<input type="checkbox"/>
Noise Meter	<input type="checkbox"/>	<input type="checkbox"/>
Camera	<input type="checkbox"/>	<input type="checkbox"/>

Thank you for completing this lengthy form. This will enable suitable and appropriate services to be matched to clients' needs.

Please make any further comments or requests for additional information, as appropriate and feel free to include any other material that you feel would promote your services.

Contact will be made within a few days of receiving your correspondence.

Judith Howard-Rees RGN OHNC Cert. Management MIOSH
Occupational Health Specialist

Date received:

Date responded:

Comments