

A.C.E.S APPLICATION PACKAGE CHECKLIST

Please tick once completed:

Application form

Work details

Notice of Employment

Payroll details

Criminal record screening consent form

Tax File Number declaration

For your information:

A.C.E.S staff are paid weekly (Tuesday) by EFT

Deferred payment options are available

Super is paid quarterly (your choice of accepted superfund)

Super is paid by **A.C.E.S** if you earn more than \$450 per calendar month.

MRSA Clearance Details

Date of swab	Result	Provided document?

Health Declaration Details

Do you or have you ever suffered from:

Please tick if yes:

- Back or neck pain
- Shoulder or joint pain
- Depression
- Any other illness or injury

If you ticked yes for any of the above, please provide details: _____

Are you currently under medical treatment for?

Please tick if yes:

- Back or neck pain
- Shoulder or joint pain
- Depression
- Any other illness or injury

Condition	Medication

Have you been immunised for:

Please tick if yes:

- | | | | |
|----------------------------|--------------------------|---------------|--------------------------|
| Tuberculosis | <input type="checkbox"/> | Influenza | <input type="checkbox"/> |
| BCG | <input type="checkbox"/> | Varicella | <input type="checkbox"/> |
| Mantoux | <input type="checkbox"/> | Pertussis | <input type="checkbox"/> |
| Diphtheria / Tetanus (ADT) | <input type="checkbox"/> | Poliomyelitis | <input type="checkbox"/> |
| Hepatitis B | <input type="checkbox"/> | | |
| Rubella | <input type="checkbox"/> | | |

Evidence of immunisation required.

Health Declaration

I declare that I have no knowledge of any condition that would hinder my ability to conduct safe and effective workplace practices for A.C.E.S Nursing Agency.

Signed: _____ **Date:** _____

Workers Compensation & Motor Vehicle Claims Details

Have you ever made a work related claim?

Please tick if yes:

- | | |
|-----------------------------------|--------------------------|
| Injury claim | <input type="checkbox"/> |
| Accident claim | <input type="checkbox"/> |
| Motor vehicle claim | <input type="checkbox"/> |
| Any other illness or injury claim | <input type="checkbox"/> |

Injury	Date of claim	Completely recovered?

Application form Declaration

Section 79 of the Workers Compensation and Rehabilitation Act 1981 states “where it is proved that the worker has at the time of entering employment in respect of which he / she claims compensation for disability, wilfully and falsely represented himself / herself as not having previously suffered from the disability a dispute resolution body may in its discretion refuse to award compensation which otherwise would be payable”.

Please initial this box as indication of acknowledgement.

I declare that all information I have provided in this application form is, to the best of my knowledge, true and correct. I acknowledge and understand that any misrepresentation or withholding of information may prejudice my employment by A.C.E.S Nursing Agency.

Signed: _____ Date: _____

WORK DETAILS

1. Specialist Ward Preference

ICU vent comp	CCU	HDU	ED
ICU non vent	Cath lab	Theatre	Homecare
MAT	NSU	Burns	REC

2. General Ward Preference

Medical	Surgical	Respiratory	Neuro
Renal	Rehab	Day surgery	Oncology
Dialysis	ENT	Ortho	Psych
Education	Aged Care	Paeds	Other

3. Public Hospital Preference

Armadale	Bentley	Fremantle	Galliers
Kalamunda	Kaleeya	King Edward	Osborne Pk
PMH	Prisons	Rock / Kwin	RPH
RPH - SPC	SCGH	Swan Dist	Other

3. Private Hospital Preference

Hollywood	JHC	Mercy	Mount
Nursing/Ho	Peel	SJOGM	SJOGS

General Availability

Please tick as appropriate:

- I will call weekly with my availability
- Periodically offer shifts to me outside of my availability
- Never call me outside of my availability
- Please book me in advance with a permanent roster
- I will consider rural assignments
- I will consider 12 hour night duty shifts (1900 – 0730)
- I work AM or PM or ND shifts (please circle)

Notice of Employment

1. **Agreement** - This agreement is between “A Consolidated Employment Service” (hereinafter called **A.C.E.S** Nursing Agency), Suite2/165, Osborne Park WA 6017 and yourself. It is a condition of membership that you agree to abide by the terms of this agreement and you are deemed to have agreed to these terms when accepting assignments fro **A.C.E.S** Nursing Agency.
2. **Status – A.C.E.S** agrees to offer you opportunities to work either Casual, Temporary or on a Permanent basis as a _____ where there is a suitable assignment with a hirer (hereinafter called the client) requiring such work. **A.C.E.S** reserves the right to offer any such assignment to such temporary workers as it may elect where that assignment is suitable for several workers. **A.C.E.S** agrees to pay salaries in accordance with the current ACES rates (above award rates) under a Collective Agreement.
3. **Assignments – A.C.E.S** makes no guarantees that it will be able to find suitable assignments but commits to acting on your behalf to find such assignments and collect outstanding payment as a result of those assignments.
4. **Reporting for duty** – Once you have accepted an assignment it is important that you report for duty as requested.
5. **Leaving A.C.E.S** – You may leave the company at any time provided one weeks notice is given in writing.
6. **Health** – Membership to **A.C.E.S** is dependant upon the truth of the statements given by you on your application form. You must be in a good state of health when reporting for duty.

7. **Change to particulars** – The Company must be informed in writing as soon as possible of any change in particulars, such as name, address, bank details and status of health.

8. **Insurance – A.C.E.S** strongly recommends that you take out professional indemnity Insurance and/or income protection insurance.

9. **Availability for work** – There is no obligation by **A.C.E.S** to provide, or the temporary worker to serve, any 'normal' number of hours in any day or week. In the event of the temporary worker declining to accept any offer of work, or failing to attend work for any reason or period this contract with unfortunately terminate. Please be punctual as **A.C.E.S** will not be able to guarantee your continual work if you are not. Please telephone **A.C.E.S** with your availability to work.

10. **Call out times** –

0530: AM staff is phoned for shifts the same day (if not already confirmed)

0730: ND staffs are phoned for next ND shift (if not already confirmed)

1000: PM staffs are phoned for shifts the same day (if not already confirmed)

1600: ND staffs are phoned for ND shift (if not already confirmed)

2130: PM staffs are phoned for AM shift the next day (if not already confirmed)

a) Bookings or changes to bookings that come in closer to the shift start times are confirmed with staff immediately.

b) All staff that have made themselves available and have not had a shift confirmed are encouraged to phone in to **A.C.E.S** at least *two hours* before they arrive for duty.

c) As much notice must be given for self cancellations (see cancellation policy: point 16.)

11. **Complaints** – Please inform the company of any complaints made against you at any time. A temporary worker having any work related complaint, such as termination or other reportable relations with the client (or any employee of the client) shall have the right to present their grievance to the Director or Senior Manager at **A.C.E.S**.

12. Uniforms – A.C.E.S provides the temporary worker with enough uniforms to cover the intended amount of work that the temporary worker intends to do. Please ensure that all normal workplace Health and Safety guidelines are met in regards to uniform and personal adornment.

13. Confidentiality – Under no circumstances is information, acquired in the course of employment, which is deemed to be private and confidential in nature, to be divulged to any persons other than the relevant authorities.

14. Remuneration – Will be deposited directly into your nominated bank account (Bank or Credit Union or otherwise) on a weekly basis.

15. Superannuation – If you have the choice of a preferred and approved Superannuation fund, **A.C.E.S** will credit 9% of your annual wage (provided it is greater than \$450.00 per calendar month) to your nominated fund.

16. Cancellation policy – Public hospitals: In the event that an assignment is cancelled within 1.5 hours of the starting time in the am you will be paid 1 hour at the applicable rate of pay of the cancelled shift. If you turn up at the site for the commencement of the shift, you will be paid 2 hours at the applicable rate. You are required to cancel your availability 2 hours prior to the am shift commencement and four and a half hours prior to the pm or night duty. A penalty of 1 hour for is shift and 2 hours for pm and night duty of applicable rates will be incurred and payable for late cancellations. Private Hospitals: two hours pay for all shifts and four hours pay if you turn up for the shift that is cancelled. Penalties apply as per Public Hospital. It is however imperative that you are contactable at all times, or the above cancellation fees will be forfeited.

I acknowledge that I have READ and UNDERSTOOD the above information and agree to adhere to A.C.E.S terms and conditions.

Name: _____

Signed: _____ **Date:** _____

PAYROLL DETAILS

1. Bank Details

Bank name:
Branch:
Account name:
BSB:
Account number:

2. Superannuation Details

Fund Name: HESTA
Fund Number:

3. Salary Sacrifice Details (optional)

Fund Name:
Fund Number:
Nominated amount:
Signed: _____ Date: _____

4. Deferred payment Details (optional)

Nominated amount to defer:
Nominated % of wages to defer:
If wages is more than \$_____ then defer:
Signed: _____ Date: _____
Any changes to the above have to be in writing, email is acceptable. This has to reach the office prior to 0900 hrs on Mondays.

Staff Performance Appraisal
/ /

Name: _____

Date:

	Expert	High Standard	Good	Adequate	Poor
Clinical Skills					
Autonomy					
Communication Skills					
Initiative					
Punctuality					
Comments:					

Presentation

	Yes	No	Has ID Badge
<p style="text-align: center;">Yes No</p> <p>Dress code: To Wear Aces/Nurses Own Uniform</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Neat Appearance

Appraised by

Name: _____

Title: _____

Health Facility: _____

Orientation to Emergency Procedures in Clinical Areas

MUST be completed on the first day in the department, and returned to the Agency within 24 hrs.

HOSPITAL: _____

Ward/Unit: _____

Nurse - please initial each section once you have familiarised yourself with the Emergency Information below:

1. EMERGENCY INFORMATION _____
2. DEPARTMENT LAYOUT INFORMATION _____
3. DEPARTMENTAL CLINICAL ROUTINE _____

A.C.E.S. Nurse: Name: _____

Title: _____

Signature: _____ Date _____

Name of Hospital Co-ordinator/C.N.: _____

Signature Co-ordinator/C.N.: _____