**Expression of Interest Form**

Hello, thank you for getting in touch and for your interest supporting Cornwall’s Mass COVID Vaccination Project.

In order to help us gather the information we need to progress with your expression of interest, please could you provide us with the information below and return it to rch-tr.jobs@nhs.net.

Personal Details – so we know how to contact you

|  |  |
| --- | --- |
| **Title** |  |
| **First Name** |  |
| **Surname** |  |
| **Email Address** |  |
| **Telephone Number** |  |

Role Interested In – so we know which role you would like to take up

|  |  |
| --- | --- |
| **Role** | **Please Tick**  |
| Immuniser  |  |
| Registered Healthcare Professional |  |
| Registered Health Care Professional Clinical Supervisor |  |
| Administrator  |  |
| Healthcare Assistant  |  |

Current Employer – so we know if you’re able to work under an agreed passport scheme or if we need to register you on Royal Cornwall Hospitals Trust Bank

|  |  |
| --- | --- |
| **Employer** | **Please Tick or Confirm Employer Name**  |
| Cornwall Partnership Foundation Trust |  |
| Cornwall Council |  |
| Kernow Health |  |
| NHS Kernow Clinical Commissioning Group |  |
| Care Home – Please Confirm Name  |  |
| Care Provider - Please Confirm Name  |  |
| Other – Please Confirm Name |  |

Profession – so we know what training we need to support you with

|  |  |
| --- | --- |
| **Profession** | **Please Tick**  |
| Registered Healthcare Professional *with* Immunisation Experience in last 12 months |  |
| Registered Healthcare Professional *without* Immunisation Experience or have not vaccinated in last 12 months |  |
| Unregistered Healthcare Professional |  |
| Admin and Clerical |  |
| Medical and Dental |  |

\*Please note, registered professional includes Nurses, Midwives and AHPs

Competence - so we know what additional training we need to support you with (for all roles except Admin and Clerical)

|  |  |  |
| --- | --- | --- |
| **Competence Title** | **Competence Achieved – Please Tick**  | **Expiry Date** |
| Immunisation Training |  |  |
| Immunisation Injection Training  |  |  |
| Anaphylaxis |  |  |
| Basic Life Support |  |  |
| Employer Mandatory Training  |  |  |

DECLARATION: I declare that the information given on this form is true and complete to the best of my knowledge.

|  |  |
| --- | --- |
| Signature:  | Date:  |