HealthNet Nursing
"Doing it together"

Reg No: 2007/065129/23

40 van Rooy street
Oewersig
Potchefstroom
2531

Fax: 018 293 1539
Tel Nr: 018 293 3254
Cell: 082 554 3680

After completion, please email the form to: healthnet@myconnection.co.za

PLEASE DO NOT MARK ANY SECTIONS ON THIS FORM
AS NOT APPLICABLE. ALL INFORMATION ASKED IS RELEVANT.

1) PERSONAL INFORMATION – PLEASE fill in all detail in PRINT.

SURNAME:

FULL NAME:

KNOW AS:

MAIDEN NAME: (Registered surname at SANC) _____

MARITAL STATUS: **MARRIED / DIVORCE / SINGLE / WIDOWED** (Circle the applicable option)

DATE OF BIRTH: _____

IDENTITY NUMBER:

PASSPORT NUMBER:_____ WORK PERMIT NR:_____

INCOME TAX NR: _____

CONTACT TELEPHONE NUMBERS:

CELL NO: _____ WORK: _____

ALTERNATIVE NR: _____

NURSING CATEGORY: (**RN / EN / ENA**)_____

RESIDENTIAL ADDRESS: POSTAL ADDRESS:

_____ _____

_____ _____

_____ _____

ARE YOU PERMANENTLY EMPLOYED? **YES / NO**

CURRENT WORK PLACE: _____

SKILLSET QUESTIONAIRRE: Please indicate in which of the following units you are able to work independently, as well as any qualifications you may have

Signature:_____

UNIT	EXPERIENCED	TRAINED	YEARS EXP
ICU - Ventilated Patients			
ICU - Non - Ventilated			
Highcare			
NICU			
Medical Ward			
Surgical Ward			
Paeds			
Maternity			
Casualty/Trauma			
COVID			
PUI			
THEATRE			
CLINICS / PHC			

MOONLIGHT AREA		
Hospital	**Interested in working there**	**Have previously worked in /currently working in hospital**
NORTH WEST		
Potchefstroom		
Klerksdorp		
GAUTENG		
Carletonville		
FREESTATE		
Welkom		
WESTERN CAPE		
Cape Peninsula		

HAVE YOU RECEIVED THE COVID-19 VACCINE?(ATTACH PROOF) _____

HAVE YOU DONE A BLS/CPR COURSE WITHIN THE LAST TWO YEARS? **YES / NO**
(If YES, please send a copy of your certificate with your application.)

NATIONALITY: _____

GENDER: **MALE / FEMALE**

HOME LANGUAGE: _____

*RACE **AFRICAN / ASIAN / COLOURED / EUROPEAN**

*DISABILITY **YES / NO**
*for employment equity legislation only

2. PROFESSIONAL REGISTRATION

INSTITUTION	REFERENCE NR
South African Nursing Council	

Signature:_____

Indemnity Cover (Professional Liability Cover): Institution and Amount Covered for:	

If you are registered with DENOSA, HOSPERSA, NEHAWU or any other trade union, please make sure that you have Liability Cover included in your membership, and for which amount you will be covered. Please provide proof along with your documents.

3. BANKING DETAILS

Name of Bank:	**Branch Code:**
Branch: (Town)	**Account Number:**

PLEASE CHOOSE AN OPTION FOR PAYMENTS:

DAILY PAYMENTS: ☐
WEEKLY PAYMENTS: ☐
MONTHLY PAYMENTS: ☐

5. REQUIRED DOCUMENTATION

Copies of the following documents are required to ensure successful registration with Healthnet Nursing Agency:

- ✓ Contract (each page must be signed)
- ✓ ID Document
- ✓ Nursing Council Receipt
- ✓ Proof of Indemnity Cover
- ✓ Any additional qualifications
- ✓ BLS/CPR certificate (if applicable)
- ✓ VACCINATION CERTIFICATE(Proof of vaccination)

6. UIF

Please mark applicable option X

I hereby confirm that my income is more than R14 872 per month and that no UIF may be deducted from my second income.

☐

I hereby confirm that my income is less than R14 872 per month and that 1% UIF may be deducted from my income.

☐

Kindly take note:

- **PLEASE BE SO KIND AND SEND US A WEEKLY SMS/WHATSAPP INFORMING US WHEN YOU ARE AVAILABLE TO WORK – 082 554 3680**
- Please note that this application does not guarantee placement at any hospital. If you should be placed at a hospital, it is only on a temporary base, and no benefits like leave, sick leave, pension fund or medical aid will be provided by the agency.
- We do daily payments for some clients if the timesheet are received by the office before 11:00. It remains your responsibility to ensure that the timesheet reaches the office in time. If timesheets are received later than 11:00, payment will only be done on the next working day.
- Should you have any queries about payments or rates, please phone the office on week days, during office hours.
  Monday – Thursday: 08:00-16:00 and Fridays: 08:00-13:00.
- If you have never worked in a certain ward, you will be required to go for 1 – 3 days' orientation(12 hour shifts), which you will not be paid for, before you can be booked there. Orientation is NOT optional.
- You may book yourself at any ward in one of our placement hospitals if you know that they are looking for someone. Just be sure to notify the office about the allocation.

I hereby confirm that all the information completed in this contract is true and correct and I understand the Code of Conduct and will abide by Healthnet rules

_____ _____

Signature **Date**

How did you find out about HealthNet Nursing Agency? _____

Signature:_____

TEMPORARY EMPLOYMENT CONTRACT

ENTERED INTO BY AND BETWEEN

HEALTHNET NURSING AGENCY

(Hereinafter referred to as the Employer)

AND

NAME:

(ID no)

NURSING CATEGORY:

RN / EN / ENA

1. DURATION

1.1 It is agreed between the parties that any interpretation of this agreement to the effect that a permanent relationship is hereby established would be erroneous and contrary to their intensions.

1.2 It is specifically agreed that the employment would either be for the completion of a project or for a fixed term or on an ad-hoc basis as and when required to do so.

2. REMUNERATION

2.1 The Employer agrees to remunerate the Employee by means of an hourly wage, which will be determined by the Hospital group where work will be done. This rate will differ from place to place and will also differ from shift to shift. Rates will be available on request.

Telephone no: 018 293 1539
Office Hours: Monday – Thursday 8:00 – 16:00
Friday: 8:00 – 13:00

2.2 Should the employee work in a ward in which he/she has not been orientated in before, 1(12hr shift) to 3 days' shifts will be unpaid for orientation purposes depending on how well you cope in the ward.

3. DEDUCTIONS

3.1 The Employer is obligated by law to deduct UIF, PAYE from wages of employee

3.2 The Employer is obligated by law to deduct in compliance with an order issued by a competent court of law

4. HOURS OF WORK

4.1 The hours of work will be on a shift bases and shift hours may vary from day to day, and from placement hospital to placement hospital, as specified by the placement hospital.

4.2 Lunch break will be stipulated by the placement hospital, as per their regulations.

5. ANNUAL LEAVE

For permanent/contract employees, leave is granted 1 hour for every 17 hours worked. Employees have the option to accrue leave by having it included in their tariff per hour (as is currently the case) or excluded from their hourly tariff per hour. The amount of accrued leave will then be paid out to the employee if and when he/or she wishes to go on leave. The leave benefit will only be applicable after a minimum of 180 hours worked.

MARK APPLICABLE BLOCK

I hereby confirm that I want to be paid the all-inclusive tariff per hour (as currently the case). ☐

I hereby confirm that I want to be paid the reduced rate of the hourly rate to make provision for my annual leave. ☐

***Please note that leave money will only be paid out after 17 shifts have been worked.**

6. SICK LEAVE

6.1 Worked into hourly tariff.

7. **MATERNITY LEAVE**

Each female employee is entitled to four months unpaid maternity leave.

8. RULES, POLICIES AND PROCEDURES

The Employee shall be obliged to abide by all company rules, policies, procedures and practises that may apply. Failure to adhere to the rules, policies and procedures of the company may result in disciplinary action, which may lead to summary dismissal in appropriate circumstances.

9. TASKS

The Employee herewith confirms that he/she is competent to perform duties assigned to them in accordance to their scope of practise and in line with all rules and regulations of the South African Nursing Council.

9. TAX

I hereby confirm that (Mark only one applicable option): ☐

- I am permanently employed and will pay 25% tax as required by law for part time work.
- I am not permanently employed and this is my first and only income, and that I will be taxed according to SARS's Tax Tables, depending in my income. Tax may vary from time to time and day to day depending on the amount earned. ☐

Signature:_____

10. FORM COMPLETION:

- Should any part of the form not be completed correctly, or options either not marked or all marked, the default options of inclusive leave tariff, 25% tax and a 1% UIF deduction will be chosen on your behalf. Please ensure you mark the correct options.

11. INFORMATION SHARING

- By signing this form, you consent that your contact information may be shared with unit managers for booking or shift arrangement purposes.

SIGNED AT _____ON THIS THE ____DAY OF _____20_____

_____ _____

FOR AND ON BEHALF OF THE EMPLOYER (HEALTHNET) **EMPLOYEE**

_____ _____

WITNESS (employer witness) **WITNESS (employee witness)**

AFTER COMPLETION PLEASE EMAIL the contract to: healthnet@myconnection.co.za

Signature:_____

DECLARATION BY EMPLOYEE
(*Confidential)*

PLEASE READ THIS FIRST

PURPOSE OF THIS FORM

This form is used to obtain information from employees for the purpose of assisting employers in conducting an analysis on the workforce profile. Employers should use this form to ascertain which employees are from designated groups in terms of the Employment Equity Act, 55 of 1998, as amended.

WHO COMPLETES THIS FORM?

Employees should fill in this form.

INSTRUCTIONS

All employers must ensure that the contents of this form remain confidential, and that it is only used to comply with the Employment Equity Act, 55 of 1998, as amended.

PLEASE NOTE:

'Designated groups', mean black people, women and people with disabilities who-

a) Are citizens of the Republic of South Africa by birth or descent; or
b) Became citizens of the Republic of South Africa by naturalization –
   (i) before 27 April 1994; or
   (ii) after 26 April 1994 and would have been entitled to acquire citizenship by naturalisation prior to that date but who were precluded by Apartheid policies

'People with disabilities' are defined in the Act as people who have a long-term or recurring physical or mental impairment, which substantially limits their prospects of entry into, or advancement in employment.

*Please note that people with disabilities have the right not to disclose their disability, unless it is in line with the inherent requirements of the job.

1. Name of employee:----------

2. Employee workplace No: ----------
   (This is the number that an employer/company/organisation uses to identify an employee in the workplace.)

3. Please indicate to which categories you belong with an '**X**' below:

Male	Female

African	Coloured	Indian	White

Foreign Nationals	

If you are not a citizen by birth, please indicate the date you acquired your citizenship: ----------

Person with a disability*	

If yes, specify nature of disability:

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4. I verify that the above information is true and correct.

Signed: ----------
Employee

Date: ----------

Signature:_____