

DOCTOR/NURSE TRAVELLER APPLICATION

Destination		Departure Date	
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PERSONAL DETAILS (PLEASE ANSWER ALL QUESTIONS)

First Name:	
Last Name:	
Date of Birth:	
Address (including Postcode):	
Mobile Telephone Number:	
Email Address:	
NEXT OF KIN	
Full Name:	
Relationship:	
Mobile Telephone Number:	
Email Address:	
YOUR DOCTOR'S CONTACT INFORMATION	
Name:	
Telephone Number:	
PASSPORT & HEALTH CARD (THIS IS REQUIRED FOR EUROPEAN TRAVEL)	
Passport Number:	
Date of Expiry:	
EHIC Card Number:	
Date of Expiry:	
Insurance Details (Provider/Policy Number):	

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ENHANCED DISCLOSURE

(To be completed by all volunteer helpers / nurses / doctors)

You must have an enhanced disclosure (DBS/PVG scheme) that is less than three years old.

Do you have enhanced disclosure?	<input type="checkbox"/>
If YES please provide your online reference number or attach a copy of the certificate	

If you do not have Enhanced Disclosure certificate, or it has expired, please contact the group leader or the Jumbulance office (info@jumbulance.org.uk) to arrange an application.

REFERENCE

(Referee only required for first time Volunteers / Nurses)

Place of Work	
Present Position Held	
Past Relevant Experience	
Name and Address of professional referee	

I confirm that I have known (name)
for years and have no reason to believe that he/she would be unsuitable in any way to act as a carer of vulnerable adults or children travelling as part of a Jumbulance holiday group.

In what capacity the referee knows this person	
Signed:	
Name:	
Address:	
Post Code:	
Date:	

If completing electronically please check this box in lieu of a signature to confirm the above

MEDICAL PROFESSIONAL INFORMATION

NURSES – Professional Details

(Only required for Nurses)

Place of Work	
Present Position Held	
Relevant Experience / Qualification	
Date of Registration	
PIN Number	
Expiry Date	
Are you a member of a professional organisation for indemnity?	<input type="checkbox"/>
If yes, please specify (e.g. RCN, RCM, UNISON, PANN, MDU)	
Membership Number	
If retired / non-practising, state for how long (years / months)	

DOCTORS – Professional Details

(Only required for Doctors)

Place of Work	
Present Position Held	
Relevant Experience / Qualification	
Date of Registration	
GMC Registration Number	
MDU Membership Number	
If retired / non-practising, state for how long (years / months)	



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GENERAL INFORMATION AND DECLARATION

Is this your first Jumbulance trip? If not, how many times have you travelled with Jumbulance previously?	<input type="checkbox"/>
Photograph / video consent* Do you give permission for photos and video of you to be reproduced for the purposes of promotion? Conditions of use - We will not use the photographs/film for any other purposes than those mentioned above. - We will not include personal details (such as postal addresses, or telephone number) on our website, printed materials or other marketing/promotional materials. - Copyright of photographs taken will remain with the property of Jumbulance Trust. Images will be held by the Jumbulance Trust for a minimum of 10 years. *Full consent form available if required	<input type="checkbox"/>
Are you a smoker? The Jumbulance Trust has a strict no smoking policy (and drinking alcohol is not permitted) on the vehicle.	<input type="checkbox"/>
Please tick to confirm that you have seen and understood our Child & Vulnerable Adult Policy	<input type="checkbox"/>
Are you fit and able?	<input type="checkbox"/>
Are you on medication?	<input type="checkbox"/>
If so state your drugs and dosage.	
Please give any other information which may be relevant: Please indicate if you have any back trouble, heart trouble, lung or chest weakness, epilepsy, diabetes, allergies etc. And provide any required details such as allergic symptoms, treatments, reactions.	

I confirm that the above information is correct and authorise the Jumbulance Trust or its representatives to seek confirmation from my Doctor if required. For insurance purposes I also confirm:

- i) That I am not travelling against the advice of a medical practitioner nor for the purpose of obtaining medical treatment abroad.
- ii) That I am not expecting to give birth before or within eight weeks following the date of arriving home

The group leader/s and/or Jumbulance Trust do not accept and you hereby release each of them from all and any liability or obligation to pay to you any compensation, costs or damages for any loss which you may incur a) as a result of any changes or delays in to the holiday arrangements and/or b) or for any damage or injury caused to you or any group member during the holiday howsoever arising.

Application's Signature: Date: [Click here to enter a date.](#)

If completing electronically please check this box to confirm you have read, understand and agree to the above



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We recently updated our privacy policy to align with the new GDPR regulations; continuing our commitment to the security of your data and transparency in its handling, full information can be obtained from the office info@jumbulance.org.uk