APPLICATION FORM

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Position Applied For: **Physiotherapist**

Title:	
Surname:	
First Names:	
Address:	
Postcode:	
Tel – work:	
evening:	
mobile:	
E-mail:	
Website:	
Which is your preferred contact number?	
Which number can we give out to clients if we need to?	
Date of Birth:	
Gender:	**Male / female**
Current Position:	
Membership of Professional Body:	
Membership No:	
Professional Indemnity Insurance:	
Certificate number:	

EDUCATION

Professional Qualifications (please continue on separate page if required):

Dates	Institution	Qualification

Any other relevant training (please continue on separate page if required):

Dates	Institution	Qualification

EMPLOYMENT HISTORY:

Start:		**Finish:**	
Employer:		**Position /Grade:**	
Brief details			
Start:		**Finish:**	
Employer:		**Position /Grade:**	
Brief details			
Start:		**Finish:**	
Employer:		**Position /Grade:**	
Brief details			
Please continue on separate page if required.			

Other Relevant Experience:

Start:		**Finish:**	
Employer:		**Position /Grade:**	
Brief details			
Start:		**Finish:**	
Employer:		**Position /Grade:**	
Brief details			
Start:		**Finish:**	
Employer:		**Position /Grade:**	
Brief details			

CLINICAL EXPERIENCE:

Please indicate your clinical experience in dealing with the following:

	No Experience	Little Experience	Moderate Experience	Good Experience
Whiplash - acute	☐	☐	☐	☐
Back Pain - acute	☐	☐	☐	☐
Soft Tissue injuries - other	☐	☐	☐	☐
Spinal Injuries	☐	☐	☐	☐
Traumatic Fractures	☐	☐	☐	☐
Structural deformities	☐	☐	☐	☐
Headaches/migraines	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
RSI	☐	☐	☐	☐
Carpal Tunnel Syndrom	☐	☐	☐	☐
Neuropathic pain	☐	☐	☐	☐
Amputees/phantom limb pain	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐
TMJ pain	☐	☐	☐	☐
Complex Regional Pain	☐	☐	☐	☐
Chronic Pain	☐	☐	☐	☐
Please add any other problems that you regularly treat in your work or areas of expertise:				

CLINICAL EXPERIENCE:

Please rate your experience/expertise in the following treatment modalities:

	No Experience	Little Experience	Moderate Experience	Good Experience
Assessment of patient and pathologies - Subjective	☐	☐	☐	☐
Assessment of patient and pathologies - Objective	☐	☐	☐	☐
Manual therapies/mobilisation	☐	☐	☐	☐
Provision of exercise programmes	☐	☐	☐	☐
Electro-therapies	☐	☐	☐	☐
Acupuncture	☐	☐	☐	☐
Chronic Pain Management - psycho-education	☐	☐	☐	☐
Chronic Pain Management - Relaxation	☐	☐	☐	☐
Chronic Pain Management - Mindfulness	☐	☐	☐	☐
Chronic Pain Management - Sleep hygiene	☐	☐	☐	☐
Chronic Pain Management - Activity pacing/scheduling	☐	☐	☐	☐
Chronic Pain Management - Exposure	☐	☐	☐	☐
Chronic Pain Management - Medication management	☐	☐	☐	☐
The Pain Toolkit	☐	☐	☐	☐
The Pain Management Plan	☐	☐	☐	☐
Please add any other problems that you regularly treat in your work or areas of expertise:				

CLINICAL EXPERIENCE:

We would be grateful if you could provide us with further information regarding your clinical skills and competences relevant to this post.

Please describe your experience in working in chronic pain management
Have you previously worked in an interdisciplinary chronic pain service? YES/NO
Have you previously worked directly with a psychologist or psychotherapist? YES/NO
If so, please describe briefly the nature of your work and role in the team.
What do you think are the key components to working with chronic pain?
What are the complications/risk factors that you would look out for working with this client group?

OTHER GENERAL INFORMATION:

Please provide details of your clinic room/s (please continue on separate page if necessary)

Name:		
Address:		
Postcode:		
Telephone		
E-mail:		
Website:		
Onsite parking?		
Disabled access?		

	Assessment	**Therapy**
What is your usual fee?		
How long are your sessions?		
Do you provide home visits?	**Yes / No**	**Yes / No**
Do you offer evening appts?		
What age of client do you see?	**Children / Adolescent / Adult / Elderly**	
How long is your waiting list?		
How many days per week do you see private clients?		
Please give details of your availability – ie days/session times.		

References:

Please provide details of two clinical referees

Name:		
Position		
Address:		
Postcode:		
Telephone		
E-mail:		

Please return to:

The Pain Service Ltd
Midloe Grange
Southoe
Cambridgeshire
PE19 5YD