EMPLOYMENT APPLICATION

POSITION APPLIED FOR:	
LOCATION:	

CONTACT DETAILS (Applicant completes)		
Employee's Full Name:		Position:
Address:		Date of Birth:
Mobile:		Home Phone:
Next of Kin:		Relationship:
Next of Kin Address:		Phone:
Are you an Australian Citizen?	Yes / No	
Are you a Torres Strait Aboriginal?	Yes / No	

MEMBERSHIPS (Applicant completes)	
Trade Union:	Member No:
Other:	

QUALIFICATIONS, LICENCES (Applicant completes)	
Trade Certificate:	
Mines Health No::	Expiry:
WA Driving Licence No:	Expiry:
St John's First Aid:	Expiry:
Police Clearance:	Expiry:
	Expiry:
	Expiry:
	Expiry:
	Expiry:
	Expiry:
	Expiry:
	Expiry:
	Expiry:

CURRENT INDUCTIONS
Expiry:
Expiry:
Expiry:

GENERAL QUESTIONS	
Are you currently employed?	Yes / No
Do you have to provide notice?	Yes / No
What is your notice period?	
Do you have any holidays planned in the next 12 months?	Dates:

EMPLOYMENT HISTORY					
	Company Name	***Location***	***Duration***	***Reason for Leaving***	***Reference / Phone No***
1					
2					
3					
4					
5					

HEALTH	
Do you suffer from any ailment or disability or are you required to take regular medication which may:	
Affect work performance? Yes / No	Affect your attendance at work? Yes / No
If "Yes" please detail:	
Have you received injuries that may affect your ability to work safely? Yes / No If "Yes" please detail:	
Have you ever submitted a Workers Compensation Claim or any Disability Claim? Yes / No If "Yes" please detail:	
Prior to starting: (Employment may depend on the results of medical tests and job suitability to employee)	
Are prepared to have a medical /hearing exam? Yes / No	Are you prepared to take a drug test? Yes / No

Industrial dermatitis or similar	□ Yes □ No Detail:
High blood pressure	□ Yes □ No Detail:
What blood group are you?	Detail:
Eye conditions (ie. colour blindness)	□ Yes □ No Detail:
Do you wear glasses/contacts	□ Yes □ No Detail:
Back or neck condition of any kind	□ Yes □ No Detail:
Spinal disorder	□ Yes □ No Detail:
Lung disorder	□ Yes □ No Detail:
Do you smoke	□ Yes □ No If yes, how many packs per day?
Hernia condition	□ Yes □ No Detail:
Heart condition of any kind	□ Yes □ No Detail:
Epilepsy	□ Yes □ No Detail:
Diabetes -	□ Yes □ No Detail:
Injury to arms, hands or fingers	□ Yes □ No Detail:
Injury to legs, feet or toes	□ Yes □ No Detail:
Hearing disorder	□ Yes □ No Detail:
Neurosis or Nervous condition	□ Yes □ No Detail:
Asthma	□ Yes □ No Detail:
Allergy to any common substances	□ Yes □ No Detail:
Vertigo	□ Yes □ No Detail:
Claustrophobia	□ Yes □ No Detail:
Have you been involved in a serious accident	□ Yes □ No Detail:
Prescribed medication currently taken	□ Yes □ No Detail:
Please list any other medication if not stated above	Detail:
Do you take any recreational drugs?	□ Yes Detail: □ No

DECLARATION:

I declare that all the information I have provided above is true and accurate:

Applicant Signature: _____ Date: _____

INTERNAL OFFICE USE ONLY:

I declare that all the relevant information above has been entered into the company recruitment database:

Company Representative: _____ Date: _____