

This information is for our records and to assist us in securing you employment.
Kindly complete this form in as much detail as possible.

Personal Details

Title: Mr / Mrs / Miss / Ms / Dr

First Name: Middle name(s):

Surname:

Address:

Postcode:

Date of Birth: Country of Birth:

Home PH: Alternative PH:

Mobile: Email:

Height: Weight:

Are you registered with a Job Network Provider: YES / NO Which one?

Job Seeker Number:

Emergency Contact Name:

Emergency Contact Telephone:

Relationship to Emergency Contact:

NB: Emergency contact must be over 18 years of age.

Citizen/Residency Status

Are you legally entitled to work in Australia? Yes No

Australian Citizen Resident Working Holiday Visa Other Visa

Screening

If required, would you be willing to undergo a police check? Yes No

If required, would you be willing to undergo a drug screen? Yes No

If required, would you be willing to undergo a medical? Yes No

Qualifications (Please circle)	Experience	Y	Experience	Y
Police Check Date Obtained <input type="text"/>	Aged Care	<input type="checkbox"/>	Cook	<input type="checkbox"/>
Manual Handling Date Obtained <input type="text"/>	Disability Services	<input type="checkbox"/>	Gardener	<input type="checkbox"/>
First Aid Date Obtained <input type="text"/>	In Home Care	<input type="checkbox"/>	Maintenance	<input type="checkbox"/>
Infection Control Date Obtained <input type="text"/>	Rehabilitation	<input type="checkbox"/>	Kitchen Hand	<input type="checkbox"/>
Chef Trade Date Obtained <input type="text"/>	Acute Care	<input type="checkbox"/>	Chef	<input type="checkbox"/>
Cert III Aged Care Disability Services Cook	Cleaning	<input type="checkbox"/>	Food & Beverage	<input type="checkbox"/>
Food Safety Date Obtained <input type="text"/>	Other			
Medication Management Date Obtained <input type="text"/>				

Medical History Sheet

To comply with our Occupational Health and Safety obligations and to avoid inadvertently placing you in a risk situation, we need to ensure we have done everything reasonably practicable to satisfy ourselves that you are capable of performing the inherent requirements of the tasks associated with any assignment for which you would normally be considered. To satisfy our responsibility, please answer the following questions and sign below where indicated.

General	Y N	Do you suffer from or have you had: (If yes & give details below)	Y N	Do you suffer from or have you had: (If yes & give details below)	Y N		
Are you taking any regular medication or drugs?	<input type="checkbox"/> <input type="checkbox"/>	Chest pain	<input type="checkbox"/> <input type="checkbox"/>	Mental / nervous disorder	<input type="checkbox"/> <input type="checkbox"/>		
Have you had a tetanus injection within the last 5 years?	<input type="checkbox"/> <input type="checkbox"/>	Angina / heart attack	<input type="checkbox"/> <input type="checkbox"/>	Anxiety	<input type="checkbox"/> <input type="checkbox"/>		
		High blood pressure	<input type="checkbox"/> <input type="checkbox"/>	Depression	<input type="checkbox"/> <input type="checkbox"/>		
		Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>		
		Pneumonia/pleurisy	<input type="checkbox"/> <input type="checkbox"/>	Ear disorder / Hearing Loss	<input type="checkbox"/> <input type="checkbox"/>		
		Bronchitis	<input type="checkbox"/> <input type="checkbox"/>	Bone Disorder	<input type="checkbox"/> <input type="checkbox"/>		
		Hay fever / sinusitis	<input type="checkbox"/> <input type="checkbox"/>	Stroke	<input type="checkbox"/> <input type="checkbox"/>		
		Asthma	<input type="checkbox"/> <input type="checkbox"/>	Fits, dizziness, faint /blackout	<input type="checkbox"/> <input type="checkbox"/>		
		Dermatitis / eczema	<input type="checkbox"/> <input type="checkbox"/>	Migraine / Frequent headaches	<input type="checkbox"/> <input type="checkbox"/>		
		Psoriasis	<input type="checkbox"/> <input type="checkbox"/>	Muscle / tendon trouble	<input type="checkbox"/> <input type="checkbox"/>		
		Injury at work	<input type="checkbox"/> <input type="checkbox"/>	Joint pain / arthritis	<input type="checkbox"/> <input type="checkbox"/>		
		Injury at sport	<input type="checkbox"/> <input type="checkbox"/>	Neck trouble	<input type="checkbox"/> <input type="checkbox"/>		
		ANY MEDICAL RESTRICTIONS?		Backache	<input type="checkbox"/> <input type="checkbox"/>	Other serious illness:	<input type="checkbox"/> <input type="checkbox"/>
				Sciatica / leg pain	<input type="checkbox"/> <input type="checkbox"/>		
		Broken bones	<input type="checkbox"/> <input type="checkbox"/>				

Have you previously suffered any workplace injury or illness? **Yes / No**
 If so, please supply the following details:

Year	Nature of Injury / Illness	Duration of Disability	Residual Limitations

I certify that the information provided on this Medical Questionnaire is true and accurate to the best of my knowledge. Failure to disclose relevant information relating to your medical history may lead to you being liable for the costs of any medical examination which we may incur in reliance on what you may have told us.

Applicant's Name

Applicant's Signature

Date

INTERVIEW NOTES:

CONSULTANT: _____

DATE: _____

		M	T	W	Th	F	Sat	Sun
Available	Early	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Late	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TRANSPORT: **OWN CAR** **PUBLIC** **OTHER**

LOCATION PREFERRED: **NORTH** **SOUTH** **EAST** **WEST**

DISTANCE WILLING TO TRAVEL:

CHECK LIST: *(office use only)*

Early AM Calls **Yes / No** **From:**

Late Night Calls **Yes / No** **Until:**

- Discuss dress code/ presentation**
- Explain pay cycle and give time sheets**
- Give performance appraisal form**
- Discuss reliability and availability / being contactable**
- Photo taken for ID badge - given / post**
- 24 hour contact number given**

WORKPRO: **completed / to complete at home** - **CIN:** **PIN:**

INTERVIEW NOTES:

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