



Employment Application

PRIVACY LEGISLATION

1. In applying for this position you will be providing HCSG with personal information. HCSG can be contacted at: PO Box 123, MUNDARING 6073, telephone: 6274 3700.
2. If you are providing HCSG with personal information, for example your name and address, or information contained on your resume, we will collect the information in order to assess your application. HCSG may also make notes or prepare a confidential report in respect of your application.
3. You agree that we may store this information until such time as the position is filled.
4. HCSG will not disclose this information to a third party without your consent.
5. HCSG is required to ask you for a National Police Clearance
6. HCSG is required to ask you for a Working with Children check if required in the area of work
7. Where you have provided us with the name and contact details of a referee in connection with your application, you should inform them that you have done so and the reason for it. You should also inform them that the information is to be used solely in connection with your application for employment or engagement and that this information collected by HCSG can be assessed by them, if they wish, by contacting HCSG.

SECTION 1	POSITION DETAILS
Position applied for:	
Date:	

SECTION 2	PERSONAL INFORMATION
Personal Details:	Title: Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Date of Birth:
	Surname (block letters):
	Given names:
	Home address:
	Suburb: State: Postcode:
	Telephone (H): Telephone (M):
	Email address:
	Languages spoken other than English:

Emergency contact details:	Name:	Relationship:
	Address:	
	Telephone (H):	Telephone (M):
	Email:	
Residency status details:	Are you a citizen of Australia? Yes <input type="checkbox"/> No <input type="checkbox"/>	Please note a copy or extract of your birth certificate/passport is required.
	Are you a permanent resident? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	If no, please provide valid visa details below with work rights:	
	Visa type/class:	Work conditions:
	Issue date:	Expiry date:
Transport:	Do you own a reliable vehicle? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Driver's Licence details:	Driver's Licence Number:	State of issue:
	Expiry date:	
	Class: Manual Automatic	Type: Probationary Full

SECTION 3		AVALIABILITY		
Are you prepared to work with?	<input type="checkbox"/> Elderly people	<input type="checkbox"/> People with disabilities	<input type="checkbox"/> Youth	
Are you prepared to work with people?	<input type="checkbox"/> In their homes	<input type="checkbox"/> Within the community	<input type="checkbox"/> Centre-based	
What type of employment are you looking for?	<input type="checkbox"/> Full time	<input type="checkbox"/> Part time	<input type="checkbox"/> Casual	
Are you prepared to work with consumers?	<input type="checkbox"/> Standard hours only	<input type="checkbox"/> After hours (weekdays)		
	<input type="checkbox"/> Weekends	<input type="checkbox"/> School holidays		

SECTION 4		REFERENCES	
Details of two work related referees (professional referees, ie previous employer, supervisor, team leader)			
Referee 1:	Name:	Organisation:	
	Telephone:	Email:	
Referee 2:	Name:	Organisation:	
	Telephone:	Email:	
Have you ever been dismissed from a position? If so, please give details:			

SECTION 5		DECLARATIONS	
The following declarations are not intended to prevent people gaining employment with HCSG, but will assist us to take due care in assessing the most appropriate placement.			

SECTION 6		WORKERS' COMPENSATION	
Have you ever claimed workers' compensation for any reason?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, please give details of each claim: <i>A previous workers' compensation claim will not necessarily preclude employment, however it is essential that you advise us of any claim you have had.</i>			
I declare that this is a correct statement		Signed:	

IMPORTANT NOTICE	
Section 79 of the Workers' Compensation and Injury Management Act 1981 gives the Workers' Compensation Dispute Resolution Body discretion to refuse to award compensation which would otherwise be payable where it is proved that the worker has at the time of seeking or entering employment, wilfully and falsely represented him/herself as not having previously suffered from the disability, the subject of the claim for Compensation.	

SECTION 7**DECLARATION**

I solemnly declare that each and every answer above is true to the best of my knowledge and belief. I understand that any false or misleading information may result in termination of employment. I agree to a medical examination, if requested, as part of my application or ongoing employment.

I acknowledge by submitting this application that I am declaring all statements in the application to be true in all respects. I acknowledge that any statement which is found to be false or deliberately misleading will make me, if employed, liable for dismissal.

Signature:

Date:

SECTION 8**CONFIDENTIALITY AGREEMENT**

I agree to be aware of, and abide by, the rules of confidentiality pertaining to all information on HCSG, its consumers, volunteers, staff and contractors.

Signature:

Date:



Medical Questionnaire

IMPORTANT NOTE

Disclosure of a medical condition or restriction does not necessarily eliminate an applicant from employment but provides confirmation on whether or not candidates are able to perform duties associated with the role.

SECTION 1 HEALTH HABITS

Do you smoke or have you ever smoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, how often per day:
Do you take illegal drugs of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, provide details:
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, average number of standard drinks per week:

SECTION 2 MANUAL HANDLING

Do you have difficulty with any of the following activities:		
Bending down, kneeling or crouching?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lifting or carrying heavy objects?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Walking on uneven ground or surfaces?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lowering, pushing or pulling heavy objects?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Going up and down stairs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Moving, holding or restraining objects?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 3 GENERAL HEALTH

Have you ever suffered from any of the following?
If you answer YES to any of the conditions below, please provide details including severity and duration of condition.

High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rheumatic fever or any heart complaint	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma, bronchitis, tuberculosis or any other lung disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gastric, duodenal or peptic ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bowel, liver or gall bladder disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Kidney or bladder disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental illness, depression, anxiety state or nervous disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Epilepsy, fainting attacks, blackouts or fits of any kind	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dermatitis or skin rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer or tumor of any kind	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Back trouble of any kind	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Whiplash from motor vehicle accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fracture(s) of upper arm or forearm	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gout or arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Repetitive strain injury of any kind	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood borne virus (eg: Aids, Hepatitis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you being treated by a doctor for any medical condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently taking any medication for a medical condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had a tetanus injection within the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had any disability, serious illness or disease not already mentioned?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever worked with asbestos fibres?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there any reason why you cannot wear safety or protective equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 4 STATEMENT AUTHORISATION

I hereby authorise an examining doctor to submit a medical report regarding the above statements, physical findings and all other investigations to HCSG.

Signature:

Date: