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PERSONAL DETAILS/JOB APPLICATION

ADVANCE FORMWORK PTY LTD

SURNAME:		GIVEN NAME/S:	
ADDRESS:			
PHONE:		MOBILE:	
EMAIL ADDRESS:			
D.O.B:		POSITION/TITLE:	
HOBBIES:			
DO YOU HAVE A DISABILITY WHICH COULD IMPACT ON JOB SAFETY, ATTENDANCE OR WORK PERFORMANCE		YES ☐ NO ☐	
IF YES PLEASE DESCRIBE:			

PLEASE SUPPLY COPIES OF THE FOLLOWING

- BLUE CARD
- WORKING AT HEIGHTS CARD
- TRADE CERTIFICATE IF APPLICABLE
- ANY OTHER TICKETS/CARDS/CERTIFICATES RELEVANT TO FORMWORK
- RESUME - INCLUDING EDUCATION AND EMPLOYMENT HISTORY
- REFERECES

DECLARATION OF APPLICANT

1. I AGREE TO ABIDE BY SAFETY RULES AND REGULATIONS WHICH APPLY
2. I DECLARE THAT THE INFORMATION I HAVE SUPPLIED BY COMPLETING THIS APPLICATION AND DOCUMENTS PROVIDED BY MYSELF ARE TRUE AND CORRECT. ANY FALSE INFORMATION WILL RENDER THE APPLICATION NULL AND VOID OR RESULT IN TERMINATION OF EMPLOYMENT
3. I AGREE TO ALLOW AND AUTHROISE THE COMPANY TO COMPREHENSIVELY CHECK MY WORKERS COMPENSATION HISTORY
4. I UNDERSTAND THAT PART OF THE APPLICATION PROCEDURE INVOLVES A PRE EMPLOYMENT MEDICAL/ HEARING TEST/DRUG TEST AND IS UNDERTAKEN AT THE EMPLOYEES EXPENSE, AND I AUTHORISE DISCLOSURE OF THE RESULTS TO ADVANCE FORMWORK PTY LTD

APPLICANTS SIGNATURE:	
DATE:	

PLEASE NOTE THAT THIS APPLICATION FOR EMPLOYMENT IS ACCEPTED WITHOUT PREJUDICE AND SHOULD NOT BE CONSIDERED AS AN OFFER OR EMPLOYMENT.

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PRE-EMPLOYMENT MEDICAL ASSESSMENT

ADVANCE FORMWORK PTY LTD

Please answer the following questions regarding your Medical History.	
Are you being treated by any doctor for any illness or taking any medications for a medical condition?	YES ☐ NO ☐
Have you been hospitalised for any illness or had any operations?	YES ☐ NO ☐
Is there a family history of any medical conditions?	YES ☐ NO ☐
Do you have any Medical Condition(s) that need to be monitored regularly, or medical issues your employer needs to be made aware of to ensure your safety and fitness for work.	YES ☐ NO ☐
Is there any reason why you cannot wear safety or protective equipment?	YES ☐ NO ☐
Have you ever tested positive in any workplace drug & alcohol-screening test?	YES ☐ NO ☐
Do you need to wear glasses for your normal work?	YES ☐ NO ☐
If so, do you have prescription safety glasses?	YES ☐ NO ☐
Have you any current medical or surgical condition?	YES ☐ NO ☐
Have you had any time off work in the last year?	YES ☐ NO ☐
Do you have Diabetes?	YES ☐ NO ☐
Do you have any known occupational allergies?	YES ☐ NO ☐

Do you have any difficulty with the following activities?	
Running 100 meters	YES ☐ NO ☐
Walking on rough ground	YES ☐ NO ☐
Kneeling	YES ☐ NO ☐
Standing for two hours	YES ☐ NO ☐
Turning your head rapidly	YES ☐ NO ☐
Using hand tools	YES ☐ NO ☐
Concentrating for any length of time	YES ☐ NO ☐
Hearing a normal conversation	YES ☐ NO ☐
Climbing any ladders	YES ☐ NO ☐
Crouching / Squatting	YES ☐ NO ☐
Sitting for two hours	YES ☐ NO ☐
Lifting or bending	YES ☐ NO ☐
Gripping firmly with one or both of your hands	YES ☐ NO ☐
Reading ordinary print / text	YES ☐ NO ☐
Repetitive movements of the hands or arms	YES ☐ NO ☐
Understanding English	YES ☐ NO ☐
Understanding Safety Signs	YES ☐ NO ☐

Do you have or have you ever had any of the following?	
Lung Problems/Asthma/Bronchitis	YES ☐ NO ☐
Suffered Blood Pressure or Heart Trouble	YES ☐ NO ☐
Fits/Seizures/Blackouts or Persistent Headaches/Migraines	YES ☐ NO ☐
Joint Problems/Fractures or Arthritis/Rheumatism	YES ☐ NO ☐
Back or neck problems	YES ☐ NO ☐
Any medical condition that prevents you from undertaking manual handling activities?	YES ☐ NO ☐
Repetitive Strain/Overuse Injury	YES ☐ NO ☐
Mental or nervous troubles	YES ☐ NO ☐
Loss of hearing/ear infections	YES ☐ NO ☐
Stomach Problems/Ulcers	YES ☐ NO ☐

Have you had any exposure to any of the following in your past jobs?	
Loud noise / explosives	YES ☐ NO ☐
Asbestos	YES ☐ NO ☐
Chemicals	YES ☐ NO ☐
Dust	YES ☐ NO ☐
Have you had a hearing test in the last 12 months?	YES ☐ NO ☐

Do you have or have you ever had any of the following?	
Tuberculosis	YES ☐ NO ☐
Any strain of Hepatitis/Jaundice/Liver Trouble	YES ☐ NO ☐
Any Type of Hernia?	YES ☐ NO ☐

If you answered "Yes" to any other of the above please provide details here.

Have you had any workers compensation claims in the past or a work related injury or illness?		YES ☐ NO ☐ (If "Yes" provide details below)
Date of Accident:	1)	2)
Name of the EMPLOYER		
Nature of the INJURY		
Total days lost (if any):		
Was a final medical certificate issued?		YES ☐ NO ☐
If "No", what is the current "FITNESS FOR WORK" status on the last medical certificate?		

OFFICE USE ONLY

Did the Employee answer "Yes" to any of the questions in this assessment? ***If Employee answers YES to any question – refer immediately to OH&S Officer

☐ **NO** (Employee answered "No" to all questions) ☐ **YES**: REFER TO OH&S MANAGER (Employee answered "Yes" to one or more questions)

Signed by Operations Manager / Safety Officer: _____ Date Signed: _____

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