

# EMPLOYMENT APPLICATION

**THIS APPLICATION FOR EMPLOYMENT DOES NOT GUARANTEE  
THAT YOU WILL OBTAIN AN INTERVIEW**



The information you provide is the first step in our employment process and will enable us to consider you for positions which may arise from time to time.

If a position becomes available and this application meets our selection criteria, you may be contacted for additional information, interview and to attend a pre-employment medical examination.

Please complete **all** sections of this application in your own handwriting and sign the declaration on the last page. Attach **copies** only of references, resume or other documents you believe are relevant to this application. (Documents attached to this application will not be returned).

The information provided in this application is used for the purpose of our recruitment and selection procedures and to support any subsequent employment offer made to you. We may seek confirmation of details from past employers, referees or other sources.

The details provided remain confidential to our organisation or appointed recruitment agency and will not be provided to any other person.

Mark the application "Private & Confidential" and post or deliver to Meercroft Care Inc at the address shown below.

**Postal Address:**

P O Box 82  
DEVONPORT 7310

**Delivery Address:**

Clements Street  
DEVONPORT 7310

**Enquiries in relation to this  
application should be made to:-**

The Nurse Manager  
Ph: (03) 6421 0111

# EMPLOYMENT APPLICATION

## PERSONAL INFORMATION

Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_

Address: \_\_\_\_\_

Ph: \_\_\_\_\_ Mob: \_\_\_\_\_ Email: \_\_\_\_\_

D.O.B: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Country of Birth: \_\_\_\_\_

Languages Spoken other than English: \_\_\_\_\_

### Next of Kin / Emergency Contact Details:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Ph: \_\_\_\_\_ Wk: \_\_\_\_\_ Mob: \_\_\_\_\_

## INFORMATION ABOUT THIS APPLICATION

What type of work are you seeking with our organisation? (Tick one or more of the following).

Registered Nurse	<input type="checkbox"/>	Receptionist	<input type="checkbox"/>	Catering	<input type="checkbox"/>	Maintenance	<input type="checkbox"/>
Enrolled Nurse	<input type="checkbox"/>	Clerical	<input type="checkbox"/>	Cleaning	<input type="checkbox"/>	Gardener	<input type="checkbox"/>
Extended Care Assistant	<input type="checkbox"/>	Qualified Cook	<input type="checkbox"/>	Laundry	<input type="checkbox"/>	Bus Driver	<input type="checkbox"/>

What type of employment are you seeking? (Tick one or more of the following).

Full Time	<input type="checkbox"/>	Casual	<input type="checkbox"/>	Shift Work	<input type="checkbox"/>	More than 20 hrs / week	<input type="checkbox"/>
Part Time	<input type="checkbox"/>	Day Work	<input type="checkbox"/>	Weekend Work	<input type="checkbox"/>	Less than 20 hrs / week	<input type="checkbox"/>

Do you have any qualifications/certificates relevant to the type of work you are seeking?

Yes  No  (If Yes, please list below).

\_\_\_\_\_  
\_\_\_\_\_

Do you have any prior experience relevant to the type of work you are seeking?

Yes  No  (If Yes, please list below).

\_\_\_\_\_  
\_\_\_\_\_

# EMPLOYMENT APPLICATION

## PREVIOUS EMPLOYMENT OR WORK EXPERIENCE HISTORY

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Name of Most Recent Work Organisation: \_\_\_\_\_

Business Address: \_\_\_\_\_

Ph: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Position Held: \_\_\_\_\_ Start Date: / / Finish Date: / /

Reason for Leaving: \_\_\_\_\_

### Please provide details of other previous employers:

Employer Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

Ph: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Position Held: \_\_\_\_\_ Start Date: / / Finish Date: / /

Reason for Leaving: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

Ph: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Position Held: \_\_\_\_\_ Start Date: / / Finish Date: / /

Reason for Leaving: \_\_\_\_\_

### Please provide details of any previous work experience:

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# EMPLOYMENT APPLICATION

## PERSONAL HEALTH INFORMATION

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Please indicate 

1. Do you currently or have you ever had or sought medical attention for pain in your back, neck, arms, shoulders, hands, or wrists?

Yes  No  (If Yes, please list details).

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2. Do you currently or have you ever had or sought medical attention for pain in your hips, legs, knees, feet or ankles?

Yes  No  (If Yes, please list details).

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3. Do you currently or have you ever had or sought medical attention for any of the following?

Epilepsy, blackouts, fits	Yes <input type="checkbox"/> No <input type="checkbox"/>	High or low blood pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart complaint	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hearing problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hernia, ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headaches (e.g. migraine)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Mental or nervous disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sight disorders, eye problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fractured or broken bones	Yes <input type="checkbox"/> No <input type="checkbox"/>
Respiratory problems (e.g. asthma, emphysema)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Skin problems (e.g. eczema, dermatitis)	Yes <input type="checkbox"/> No <input type="checkbox"/>

4. Are you aware of any reason which may prevent you from performing the following tasks?

Wearing vinyl / rubber gloves	Yes <input type="checkbox"/> No <input type="checkbox"/>	Write reports and documents	Yes <input type="checkbox"/> No <input type="checkbox"/>
Lift heavy objects, make beds	Yes <input type="checkbox"/> No <input type="checkbox"/>	Use computers, telephones	Yes <input type="checkbox"/> No <input type="checkbox"/>
Use vacuum cleaners, mops	Yes <input type="checkbox"/> No <input type="checkbox"/>	Clean incontinence	Yes <input type="checkbox"/> No <input type="checkbox"/>
Use soaps, detergents, bleaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Wear workplace approved shoes for long periods of time	Yes <input type="checkbox"/> No <input type="checkbox"/>

# EMPLOYMENT APPLICATION

## GENERAL INFORMATION

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1. Why are you applying for work at Meercroft? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Have you ever made a claim for Worker's or M.A.I.B. compensation? Yes  No

**If Yes:-**

Date of Claim:     /     /     Employer Name: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Reason for claim: \_\_\_\_\_  
\_\_\_\_\_

3 Please list any personal qualities you have which you believe may assist your application.

\_\_\_\_\_  
\_\_\_\_\_

4 Please provide details of two people we may contact as referees if you have not stated them on your resume. They are **NOT** to be family members and where possible, one to be from your last place of employment.

**Employment Referee:**

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Ph: \_\_\_\_\_ Wk: \_\_\_\_\_ Mob: \_\_\_\_\_

**Employment Referee:**

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Ph: \_\_\_\_\_ Wk: \_\_\_\_\_ Mob: \_\_\_\_\_

# EMPLOYMENT APPLICATION

## DECLARATION OF APPLICANT

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I hereby authorise Meercroft Care Inc to obtain references and speak to referees to verify any information relevant to this application.

I certify that the information given in this application is true and complete and I am aware that any inaccurate statements made herein or information deliberately withheld may later jeopardise my employment and / or some entitlements claimed by me under worker's or other forms of compensation.

I acknowledge that this application does not constitute an offer of employment and that any offer subsequent to this application will be subject to satisfactory completion of a pre-employment medical examination and satisfactory completion of a probationary period.

Should this application be successful, I agree to abide by all rules, policies and procedures of Meercroft Care Inc.

We require evidence of your ability to legally work in Australia either  
(Australian Citizenship, Australian birth certificate, Australian passport if born in Australia)  
(Passport of your country of citizenship / visa. If born overseas)

**Applicant Name:** \_\_\_\_\_

**Signature of Applicant:** \_\_\_\_\_

**Witness Name:** \_\_\_\_\_

**Signature of Witness:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_