



Standard Application Form

General Information

How Long Available for Work:		Visa Status:	
Position Sought:		Availability:	
Surname:		Given Names:	
Address:	_____ <small>Number Street Suburb Post Code</small>		
Phone:	Home: _____ Mobile: _____		
D.O.B (optional):		Age (optional):	
Email:			

In case of an emergency notify:			
Surname:		Given Names:	
Phone:	Home: _____ Mobile: _____		
Address:	_____ <small>Number Street Suburb Post Code</small>		

HAVE YOU WORKED FOR US BEFORE: <small>if yes complete below</small>			
Department/Room		Supervisor:	
Approx. Dates:	From: ____/____/____ To: ____/____/____		
Reason For Leaving:	_____ _____ _____		

Employment History

Details of previous employers: (list at least 3, if no resume attached)				
Dates	Company	Position	Duties	Reason for leaving

List three professional referees: (please be aware we may call any references listed here)				
Name	Company	Address	Position	Phone



Finesse
FOODS







Miscellaneous

Drivers License No:		State:	
Expiry date:		Class:	

Please tick the below:

Are you prepared to work:

Casual: Yes No

Part time: Yes No

Full time: Yes No

Away from home: Yes No

Shift Work: Yes No

In Bunbury: Yes No

In Dardanup: Yes No

Hours You Are Available:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Do you have your own transport: Yes No

Please list any certificates or training you have or are undertaking:

Some of our positions will require a current police clearance, if this is a requirement for a position that you are applying for, will you be able to provide one. Yes No

Do you have any holidays booked in the near future: Yes No

If yes please give details: From: ___/___/___ To: ___/___/___

How have you heard about us:

Word of Mouth Internet Job Boards Accommodation Other : _____





Physical Health History

Physical/Health History

IMPORTANT

Section 79 of the Workers Compensation and Rehabilitation Act 1981

“Where it is proved that the worker has, at the time of seeking or entering employment in respect of which he/she claims compensation for a disability, wilfully and falsely represented themselves as not having previously suffered from a disability, a dispute resolution body may in its discretion refuse to award compensation which otherwise would be payable.”

Worker to complete: (please circle your answer, these may be discussed further)			If Yes, please explain
Are you required to take medication which may affect your work performance?	Yes	No	
Are you required to take medication which may affect your attendance at work?	Yes	No	
Are you willing to take a medical examination should one be requested?	Yes	No	
Are you willing to undertake random drug and alcohol testing?	Yes	No	
Have you had time off work in the last year for illness or injury?	Yes	No	
Are you currently being treated by a doctor for any illness or injury ?	Yes	No	
Have you had injury or illness which may impact on your ability to perform on the job?	Yes	No	
Do you have a current Workers Compensation claim/Have you previously made a Workers Compensation claim?	Yes	No	
Do you presently or have you ever had back, neck, shoulder, knee or joint problems?	Yes	No	
Is there any reason why you cannot wear safety or protective equipment?	Yes	No	
Have you had a Tetanus injection in the last ten years?	Yes	No	
Have you ever been refused Life Insurance, Disability Insurance, Employment or Military Service?	Yes	No	
Are you affected by heights or confined spaces?	Yes	No	
Known allergies: Medications Foods Other (specify)	Yes	No	





Place an X in the box beside any condition(s) you have or have had at any time in your life

- | | |
|---|---|
| <input type="checkbox"/> Blood pressure
<input type="checkbox"/> Lung problems/Asthma
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Hernia
<input type="checkbox"/> Fits/Seizures/Blackouts
<input type="checkbox"/> Persistent headaches/Migraines
<input type="checkbox"/> Diabetes (sugar)
<input type="checkbox"/> Any joint problems/fractures
<input type="checkbox"/> NONE of the above | <input type="checkbox"/> Repetitive strain/overuse injury
<input type="checkbox"/> Arthritis/Rheumatism
<input type="checkbox"/> Mental or nervous troubles
<input type="checkbox"/> Loss of hearing or ear infections
<input type="checkbox"/> Visual impairments
<input type="checkbox"/> Stomach problems/Ulcers
<input type="checkbox"/> Hepatitis/Jaundice/Liver trouble
<input type="checkbox"/> Skin disorders/Dermatitis
<input type="checkbox"/> NONE of the above |
|---|---|

Please comment on all those marked with an X (use the back of this sheet if necessary)

Place an X in the box beside each activity with which you have difficulty

- | | | |
|--|--|--|
| <input type="checkbox"/> Running 100 metres
<input type="checkbox"/> Crouching
<input type="checkbox"/> Standing for two hours
<input type="checkbox"/> Gripping firmly with both hands
<input type="checkbox"/> Hearing a normal conversation
<input type="checkbox"/> Understanding English | <input type="checkbox"/> Climbing a ladder
<input type="checkbox"/> Kneeling
<input type="checkbox"/> Lifting or bending
<input type="checkbox"/> Using hand tools
<input type="checkbox"/> Reading ordinary print | <input type="checkbox"/> Walking on rough ground
<input type="checkbox"/> Sitting for two hours
<input type="checkbox"/> Turning your head rapidly
<input type="checkbox"/> Repetitive movements of the hands or arms
<input type="checkbox"/> Concentrating on what you are doing |
|--|--|--|

Please comment on those marked with an X

Have you had any exposure to the following in your past jobs?

If Yes please give details

	Yes	No	
Loud noise/explosives/gunfire			
Asbestos			
Chemicals			
Radiation			
Dust			





Are you aware of any previous or current injuries or disabilities that may affect you work performance? Yes No

If yes please give details: _____

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 understand that I may also be required to undergo baseline health tests on termination of employment.

Statement Authorisation

I hereby authorise the examining doctor to submit a medical report regarding the above statement, physical findings, audiogram and all other investigations to my employer.

We ask that all employees use a Finesse Foods approved doctor when requiring medical attention.

Applicant's signature:		Date:	
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