



ALEXANDER DOWNS GROUP

Name:

Position:

Date: / /

OFFICE USE ONLY				
Interviewed by				
Induction Date				
Position				
Rate of pay				
Commencement Date				
Q Fever		Drug & Alcohol		Medical
Comments:				



EMPLOYEE'S DETAILS	
Name:	
Address:	
Suburb:	Post Code:
Date of birth: / /	Marital status:
Home phone:	Mobile:
License Number:	License Class (i.e. C, HR)
Email:	

EMPLOYMENT DETAILS		
Have you previously worked in a Meat / Farming Industry? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, please give details below:		
Position Held	Location	Date
Position Held	Location	Date
Have you previously applied for a position with the Alexander Downs Group? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, please give details:		

EDUCATION / TRAINING		
High School Attended		
From	To	Level Reached
Further Education		
From	To	Certificate obtained

OCCUPATIONAL LICENSES AND CERTIFICATES CURRENTLY HELD (e.g. First Aid)	

EMPLOYMENT HISTORY (start with present information first)		
Company	From:	To:
Position Held		
Reason for Leaving		
Company	From:	To:
Position Held		
Reason for Leaving		
Company	From:	To:
Position Held		
Reason for Leaving		

EMPLOYMENT REFERENCES (current)		
Name:	Company:	Telephone
1.		
2.		



MEDICAL HISTORY (MUST BE COMPLETED)

Are you taking any medicines, tablets or having any treatment now? (If yes please give details below) Yes No

Details:

Do you suffer from or have you ever had the following below: (If yes please give details)

- | | | |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fit/ Epilepsy | <input type="checkbox"/> Asbestos or Silicosis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mental/ Nervous Disorders | <input type="checkbox"/> Repetition Strain |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Headaches/ migraine/ giddiness | <input type="checkbox"/> Overuse Syndrome |
| <input type="checkbox"/> Chest Pain/ Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Varicose Veins causing trouble |
| <input type="checkbox"/> Rheumatic Fever/ Heart Murmur | <input type="checkbox"/> Back pain/ Injury/ Sciatica | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Joint pain / Arthritis | <input type="checkbox"/> Strain or Sprain of any king |
| <input type="checkbox"/> Wheeze/ Asthmas/ Bronchitis | <input type="checkbox"/> Foot Trouble | <input type="checkbox"/> Allergies e.g. Penicillin |
| <input type="checkbox"/> TB Emphysema | <input type="checkbox"/> Muscle/ Tendon Trouble/ Tenosynovitis | <input type="checkbox"/> Gastroenteritis |
| <input type="checkbox"/> Pneumonia/ Pleurisy | <input type="checkbox"/> Painful Arm/ Tennis elbow | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Hay Fever/ Sinusitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Recurrent Indigestion/ Dyspepsia |
| <input type="checkbox"/> Stomach/ Peptic Duodenal Ulcer | <input type="checkbox"/> Skin Disorders/ Rashes | <input type="checkbox"/> Typhoid or Paratyphoid |
| <input type="checkbox"/> Passing/ Vomiting Blood | <input type="checkbox"/> Eye/ Vision Problem | <input type="checkbox"/> Any Chronic illness or disease |
| <input type="checkbox"/> Indigestion/ Bowel Disorder | <input type="checkbox"/> Ear/ Hearing Problem | <input type="checkbox"/> Serious Injury |
| <input type="checkbox"/> Jaundice/ Hepatitis/ Gallstones | <input type="checkbox"/> Head/ Neck Injury/ Whiplash/ Concussion | <input type="checkbox"/> Blackouts/ Fainting |
| <input type="checkbox"/> Kidney/ Bladder Disease/ Stones | <input type="checkbox"/> Anxiety/ Fear of Heights/ Confined Spaces | <input type="checkbox"/> Painful shoulder/ wrist |

Any other illness/ undeclared conditions? (If yes please give details below) Yes No

Details:

Have you had an accident or operation? (If yes please give details below) Yes No

Date/ Year	Details:	
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Date/ Year	Details:	
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Have you had an accident or operation? (If yes please give details below) Yes No

Date/ Year	Details:	
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Date/ Year	Details:	
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GENERAL

How many sick days have you taken during the past 12 months?

No of days:	Cause:
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Are you prepared to work overtime? Yes No

Are you prepared to wear all PPE supplied by the company? Yes No

Are you prepared to undergo a medical examination prior to and during your employment by this company's Occupational Health Staff or a Medical Practitioner? Yes No

Are you prepared to undergo random Drug & Alcohol testing if directed by the Alexander Downs Group? Yes No

Have you ever been convicted of a felony or misdemeanour? (If yes, please give details below) Yes No

Date	Disposition of case
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GENERAL					
Have you ever worked with any of the following?					
<input type="checkbox"/> Chemicals	<input type="checkbox"/> Asbestos	<input type="checkbox"/> Dust	<input type="checkbox"/> Heat	<input type="checkbox"/> Noise	<input type="checkbox"/> Radiation
Have you had health problems working with these? Yes <input type="checkbox"/> No <input type="checkbox"/>					
When was your last Tetanus Injection?					
Have you been vaccinated against Q Fever? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Have you contracted Q Fever? (If yes please give details below)			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Details:					

WORKERS COMPENSATION			
Date of Injury	Employer	Nature of Injury	Length of time off work
1			
2			
3			
4			

Acceptance	
<p>I certify that all statements I've made in this application are true and correct to the best of my knowledge. I agree that any miss statement may subject me to discharge at any time in the event that I am engaged. I authorise Alexander Downs to investigate and make enquiries concerning my background. I hereby release Alexander Downs or any agent appointed by Alexander Downs Group and all their respective employees from any liability related to or arising out of the exchange of such information. If I am employed by the Alexander Downs Group, I agree that my continued employment may be contingent upon satisfactorily passing a physical examination at any time to establish my capability to properly or safely perform my duties. I fully understand and appreciate that a health interview and examination, including drug and alcohol testing and Q Fever vaccination may be required. I agree that if required Medical Reports may be obtained from my Doctor and/or Specialist by the staff of Alexander Downs Group.</p> <p>I understand and accept that Alexander Downs Group is a security controlled work place including the use of security cameras and the use there of. I also understand and accept that at any time during my employment at Alexander Downs Group I could be subject to a random drug and alcohol test.</p>	
Signature:	Date: