

APPLICATION FOR EMPLOYMENT

HORNBY TRANSPORT SERVICES PTY LTD
 22 INVESTIGATOR DRIVE
 UNANDERRA NSW 2526

FULL DISCLOSURE IS REQUIRED

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PERSONAL (ANSWER ALL QUESTIONS OR APPLICATION WILL BE INVALID)

FULL NAME: _____		
ADDRESS: _____	STATE: _____	POSTCODE: _____
DATE OF BIRTH: _____		
HOME PHONE: _____	MOBILE PHONE: _____	WORK PHONE: _____

EDUCATION

NAME & LOCATION	FROM	TO	LEVEL ATTAINED	DATE GRADUATED
HIGH SCHOOL:				
UNI (TAFE etc.)				
OTHER:				

SPECIAL SKILLS OR TRAINING (APPLICABLE TO EMPLOYMENT)

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EMPLOYMENT (START WITH MOST RECENT, ATTACH FURTHER DETAILS IF NEEDED)

DATE FROM:	DATE TO:	DESCRIBE DUTIES:
EMPLOYER:		
SUPERVISOR'S NAME:		
PHONE NO:	REASON FOR LEAVING:	
MAY WE CONTACT EMPLOYER AT ABOVE PHONE NUMBER? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DATE FROM:	DATE TO:	DESCRIBE DUTIES:
EMPLOYER:		
SUPERVISOR'S NAME:		
PHONE NO:	REASON FOR LEAVING:	
MAY WE CONTACT EMPLOYER AT ABOVE PHONE NUMBER? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DATE FROM:	DATE TO:	DESCRIBE DUTIES:
EMPLOYER:		
SUPERVISOR'S NAME:		
PHONE NO:	REASON FOR LEAVING:	
MAY WE CONTACT EMPLOYER AT ABOVE PHONE NUMBER? <input type="checkbox"/> YES <input type="checkbox"/> NO		

WORKERS COMPENSATION HISTORY (LAST 10 YEARS)

EMPLOYER	ACCIDENT	INJURY	COMP.PERIOD		LOST EMPLOYMENT IN DAYS
			FROM	TO	

PROVIDE DETAILS OF ANY LASTING INJURY OR DISABILITY:

ADDITIONAL INFORMATION (PLEASE ANSWER EACH QUESTION / ITEM)

POSITION APPLIED FOR:	MEMBER OF WHICH UNION?
<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> CASUAL <input type="checkbox"/> OTHER	
LIST ANY DAYS/HOURS WHEN YOU ARE UNABLE TO WORK:	
HAVE YOU WORKED FOR THIS COMPANY BEFORE?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IF YOU WORKED FOR US BEFORE – WHEN?	
PREVIOUS POSITION:	REASON FOR LEAVING?
I AGREE TO WORK SHIFT WORK / OVERTIME IF REQUIRED?	<input type="checkbox"/> YES <input type="checkbox"/> NO
I AGREE TO SUPPLY A LICENCE HISTORY PRINTOUT	<input type="checkbox"/> YES <input type="checkbox"/> NO
I AGREE TO A MEDICAL EXAMINATION BY A COMPANY NOMINATED DOCTOR	<input type="checkbox"/> YES <input type="checkbox"/> NO

PERSONAL REFERENCES

NAME	ADDRESS	RELATIONSHIP	PHONE NUMBERS

LIST ONLY PERSONS WE MAY CONTACT (BE SURE TO INCLUDE PHONE NUMBERS)

READ CAREFULLY:
INFORMATION PROVIDED IN THIS APPLICATION IS:

- a) True and correct to the best of my knowledge, and;
- b) I understand that if employed, any false statements in here will be cause for instant dismissal, and;
- c) I am aware that a 3 month probation period applies to me

APPLICANT’S SIGNATURE _____ **DATE** _____

OFFICE USE ONLY SECTION – DO NOT WRITE IN THIS SECTION
INTERVIEW DETAILS

INTERVIEWER	DATE	COMMENTS

DETAILS OF DRIVING EXPERIENCE / ACCIDENTS

HORNBY TRANSPORT SERVICES PTY LTD
 20-22 INVESTIGATOR DRIVE
 UNANDERRA NSW 2526

FULL DISCLOSURE IS REQUIRED

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PERSONAL

NAME:		DATE:	
LICENCE NO:		RENEWAL DATE:	
CLASSES HELD:		TWU MEMBERSHIP NUMBER:	
STATE ISSUED:		CURRENT DEMERIT POINTS HELD:	

LICENCE HISTORY (AN UP TO DATE RTA LICENCE PRINTOUT IS REQUIRED)

DUI / NEGLIGENT DRIVING DETAILS	FROM	TO	BAC LEVEL	COURT ACTION

SPECIAL SKILLS OR TRAINING (APPLICABLE TO EMPLOYMENT)

DRIVING EXPERIENCE (NOTE: CATEGORY MEANS REFERENCE, GENERAL ETC)

CATEGORY:	YEARS EXPERIENCE:	EMPLOYER NO 1	PH.No:
TYPE OF VEHICLE:		EMPLOYER NO 2	PH.No:
LOAD TYPE(S):		EMPLOYER NO 3	PH.No:
ACCIDENT DETAILS:		EMPLOYER NO 4	PH.No:
		EMPLOYER NO 5	PH.No:
MAY WE CONTACT EMPLOYER AT ABOVE PHONE NUMBER? <input type="checkbox"/> YES <input type="checkbox"/> NO			
CATEGORY:	YEARS EXPERIENCE:	EMPLOYER NO 1	PH.No:
TYPE OF VEHICLE:		EMPLOYER NO 2	PH.No:
LOAD TYPE(S):		EMPLOYER NO 3	PH.No:
ACCIDENT DETAILS:		EMPLOYER NO 4	PH.No:
		EMPLOYER NO 5	PH.No:
MAY WE CONTACT EMPLOYER AT ABOVE PHONE NUMBER? <input type="checkbox"/> YES <input type="checkbox"/> NO			
CATEGORY:	YEARS EXPERIENCE:	EMPLOYER NO 1	PH.No:
TYPE OF VEHICLE:		EMPLOYER NO 2	PH.No:
LOAD TYPE(S):		EMPLOYER NO 3	PH.No:
ACCIDENT DETAILS:		EMPLOYER NO 4	PH.No:
		EMPLOYER NO 5	PH.No:
MAY WE CONTACT EMPLOYER AT ABOVE PHONE NUMBER? <input type="checkbox"/> YES <input type="checkbox"/> NO			

HEALTH / MEDICAL INITIAL DECLARATION

HORNBY TRANSPORT SERVICES PTY LTD
 20-22 INVESTIGATOR DRIVE
 UNANDERRA NSW 2526

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JOB APPLIED FOR – LOCATION

PRINT YOUR FULL NAME:

I DECLARE: THE FOLLOWING INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE

SIGNED: _____

LIST ANY PHYSICAL INCAPACITY YOU SUFFER (OR HAVE SUFFERED FROM)

PERSONAL DOCTOR'S NAME & ADDRESS OF PRACTICE (INCLUDE PHONE NUMBER)

ANSWER YES / NO IN EACH CATEGORY

DRUG DEPENDANCY	HIGH BLOOD PRESSURE	ASBESTOSIS / SILICOSIS
REPETITION STRAIN	NOISE INDUCED HEARING DEFECT	ASTHMA OR BRONCHITIS
DERMATITIS	DISEASE OF LIMBS OR JOINTS	SKIN DISORDER
HEART PROBLEM(S)	BACK PROBLEMS OF ANY KIND	VARICOSE VEINS
TUBERCULOSIS	FAINING GIDDINESS OR FITS	RUPTURE OR HERNIA
EYESIGHT DEFECTS	RECURRENT INDIGESTION/ DYSPEPS	MUSCLE – JOINT ILLNESS
PNEUMONIA	NERVOUS / MENTAL AILMENT	TYPHOID / PARATYPHOID
EPILEPSY - DIABETES	KIDNEY / BLADDER DISEASE	NECK / SPINAL AILMENT
SHORTNESS OF BREATH	SLEEP DISORDER please state	STRAIN OR SPRAIN
ALCOHOLISM	CHRONIC ILLNESS please state	SERIOUS INJURY
MIGRAINE - HEADACHES	STOMACH – DUODENAL ULCER	AIDS OR HEPATITIS B
SINUSITUS	ALLERGIES eg.PENICILLIN	VENEREAL DISEASE

PERSONAL (FAMILY DETAILS)

RELATIONSHIP	SURNAME	FIRST NAMES	CHILDREN - AGE		FAMILY PHONE NO.
			0-10	10+	
NEXT OF KIN – EMERGENCY CONTACT DATA (include phone numbers)					

PERSONAL HEALTH DETAILS – HEALTH STATEMENT

GENERAL DESCRIPTION:	HEIGHT () cm	WEIGHT () kg
EYE COLOUR ()	HAIR COLOUR ()	
HAVE YOU PREVIOUSLY WORKED IN NOISY JOBS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
IF YES, HOW LONG?		
DO YOU WEAR GLASSES / CONTACT LENSES?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
IS YOUR SIGHT DEFECT NOTED ON YOUR LICENCE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DO YOU SUFFER FROM ANY DRUG(S) DEPENDANCY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HAVE YOU EVER SUFFERED FROM SLEEP APTNIA?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

APPLICANTS: ANSWER ALL QUESTIONS THEN READ AND SIGN BELOW

The information provided by me in this “MEDICAL DECLARATION” (2 pages) is true and complete to the best of my knowledge. I understand that by giving willful and false answer(s) I may jeopardize any claim for Workers Compensation and lead to my dismissal.

APPLICANT’S SIGNATURE _____ **DATE** _____

OFFICE USE ONLY SECTION – DO NOT WRITE IN THIS SECTION

INTERVIEW DETAILS

INTERVIEWER	DATE	COMMENTS