



POSITION APPLYING FOR:

Date:

Full Time ☐ Part Time ☐ Casual ☐ Temp ☐

Are you currently or have you previously been employed by SWIAA?

Yes ☐ No ☐

PLEASE NOTE:

1. Do not enclose original documents, qualifications or references. Photocopies will suffice.
2. *Please bring originals if called for an interview.*
3. Appointment is subject to proof of eligibility to work in Australia.
4. Any statement on this form, which is found to be deliberately misleading, will make you liable for dismissal

SECTION A - PERSONAL DETAILS

Preferred form of address: Mr ☐ Mrs. ☐ Miss. ☐ Ms ☐ Dr/Prof. ☐ Other. ☐

SURNAME: NAME:

Former Names.....(If applicable)

POSTAL ADDRESS:

POST CODE:

Date of Birth / / (DD/MM/YY) Male: ☐ Female ☐ Other ☐

TELEPHONE NUMBERS:

Business: Home: Fax:

Mobile: E-mail:

Emergency/Contact.....

Address.....Postcode.....

Emergency Telephone Numbers:

Business: Home: Mobile:

Are you an Australian Citizen or Resident: Yes ☐ No ☐

If the answer is no, do you have a Working Visa? Yes ☐ No ☐ (if yes, please provide a copy)

Where did you see or hear about the vacancy advertised? (Please tick your response)

☐ Newspaper ☐ Walk in ☐ Friend/relative ☐ Website.....

☐ Other (please indicate).....

SECTION B - EQUAL EMPLOYMENT OPPORTUNITY

This section is for compliance with EEO legislation only

Was English the first language of: *(Please tick your selection)*

Yourself Yes ☐ No ☐ Your Mother Yes ☐ No ☐ Your Father Yes ☐ No ☐

Are you from a racial, ethnic or ethno-religious group, which is a minority in Australian society? Yes ☐ No ☐

Are you of Aboriginal or Torres Strait Islander origin? Yes ☐ No ☐

Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐

It is SWIAA Village policy to welcome applications from people with disabilities and to attempt to meet reasonable / appropriate work-related requirements of employees.

Do you have a disability Yes ☐ No ☐

If Yes, please indicate how the workplace might be adjusted to overcome any barriers that may affect your performance.

.....
.....
.....

SECTION C - EDUCATION

1. SECONDARY *(Show details of highest examination passed or attempted or attach copy of Certificate)*

NAME OF EXAMINATION: Year 10

Year 11

Year 12

2. TERTIARY Name of Institution	Course Undertaken	From	To	QUALIFICATIONS AWARDED <i>(Please attach copies of your results)</i>

3. OTHER SKILLS AND QUALIFICATIONS

You may include professional/technical qualification, courses, fluency in languages, office skills, computer skills

.....

Current Professional Registration Number:..... Valid to: ____ / ____ / ____ *(dd/mm/yy)*
(A copy of Registration must be attached)

Professional Membership(s):

.....
.....

Languages spoken other than English:

.....

Do you have a current drivers license? Yes ☐ No ☐ If yes, which class? _____ Expiry Date: ____ / ____ / ____ Clerical

staff (skills & experience): ☐ Shorthand ☐ wpm Typing (wpm _____)

Office Machine experience: Yes ☐ No ☐

SECTION D - EMPLOYMENT HISTORY

Please indicate where you have worked before. Include overseas as well as Australian work experience. Voluntary work experience may also be included. If space provided is insufficient and you wish to provide more detailed work history, please attach extra pages to this form. If you are appointed, for previous service to be recognised, a detailed Statement of Service from your previous employer or Nursing Service Record Book will be required.

EMPLOYER	DATES		POSITION HELD
Present Position	From	To	

SECTION E - SPECIAL NEEDS

If you have any special needs to enable you to attend for an interview please list them below or contact the contact person for the advertised position

.....
.....

SECTION F - OTHER

REFERENCES: (regarding employment related information)

Please provide names and addresses of two referees, *one of which should be your present or most recent supervisor.*

1. Name:	Title:
Organisation:	
Address:	
	Post Code:
Telephone No:	

2. Name:	Title:
Organisation:	
Address:	
	Post Code:
Telephone No:	

Applicant's Statement and Declaration:

Please tick (✓) your response to the following questions

Are you aware of any circumstances regarding your health, which may interfere with the satisfactory discharge of the duties of the position for which you are now applying? Yes ☐ No ☐

If yes, please comment:.....

I agree to SWIAA Village requesting confidential reports from my previous employer
Yes ☐ No ☐

I understand that any discussion or disclosure of records or information concerning residents and staff generally is a serious betrayal of trust and could mean instant dismissal Yes ☐ No ☐

That I will notify the Executive Manager (in writing) within 14 days, should I appear in court and be convicted of a criminal offence Yes ☐ No ☐

That if employed as a trainee, my continued employment during my period of training, will be subject to maintaining satisfactory progress in both theoretical and practical training Yes ☐ No ☐

That all statements in my application are correct to my knowledge and that the making of a false statement may lead to dismissal Yes ☐ No ☐

That it is a condition of my employment that an ID card containing my photograph must be worn or carried at all times (if applicable) and be produced on request
Yes ☐ No ☐

I am aware that a criminal record check will be conducted if I am recommended for appointment. I declare the information contained in this application is true. I understand that any intentional omission from this application or false statement may lead to my dismissal Yes ☐ No ☐

I declare that the qualifications I have asserted to have are genuine and acknowledge that false claims may lead to my dismissal and/or prosecution for any relevant offence
Yes ☐ No ☐

Family Name

First Name/s.....

Signature.....

Date / / (dd/mm/yyyy)

Information Regarding the Employment Health Assessment Questionnaire

Please note: The information provided will be treated in the strictest confidence
Please ensure that you read the information provided on the following pages before completing the questionnaire

Staff Health and Wellbeing Service

Evidence of Protection Against Specified Infectious Diseases

In accordance with the NSW Health Policy directive: "Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases" (PD 2007_006), all staff employed by SWIAA Village must be 'protected' against the specified infectious diseases.

The evidence required to prove 'protection' is specific. The evidence can be based on immunisation evidence, immunity evidence or assessment evidence, or a combination of all. The evidence can be either:

- A statement from your General Practitioner clearly indicating how you comply with the acceptable evidence
- A certified copy of a 'NSW Health Adult Vaccination Record Card' or equivalent
 - o To be considered as evidence, all entries on any vaccination record must be individually signed with the immunisation providers details clearly noted (a provider stamp or medical practice stamp is acceptable)
- A certified copy of a written record of vaccination signed by the provider and/or serological confirmation of protection

Please note: A statutory declaration is not acceptable evidence.

Please note: the following are the minimal criteria for evidence, and any evidence provided must address these criteria.

Vaccination and/or Immunity Evidence

<i>Disease</i>	<i>Acceptable Evidence Criteria</i>
Diphtheria, Tetanus and Pertussis	Documented evidence of one dose of adult type dTpa vaccine
Hepatitis B	Documented evidence of completion of an age appropriate course of Hepatitis B vaccines over the preferred timeframe AND Documented evidence of serology indicating protective antibody levels (anti-HBs \geq 10 IU/mL post vaccination, OR , Documented evidence of past infection indicated by positive serology (anti HBc).
Measles, Mumps and Rubella	Documented evidence of completion of the two dose course of MMR vaccine at least one month apart, OR , Documented evidence of positive serology ie IgG for Measles, Mumps and Rubella
Varicella	Documented evidence of completion of an age appropriate course of Varicella vaccine/s, OR , Documented evidence of positive serology ie IgG for Varicella, OR , Documented evidence of a physician diagnosed Shingles, OR , Documented evidence of Chicken Pox

TB Assessment Evidence

<i>Assessment Type</i>	<i>Acceptable Evidence Criteria</i>
Skin Test (TST)	Documented evidence of a skin test being completed and read within the last 12 months. If documented evidence showing that a skin test is contraindicated is provided, then documented evidence of a chest X Ray being completed and reviewed within the last 12 months is an acceptable alternative.

Mitigating Circumstance Evidence

- **Where vaccination is contraindicated:** Should you believe that vaccination is contraindicated for you, you will need to provide evidence from your General Practitioner clearly outlining the reasons why vaccination is contraindicated.
- **Where previous vaccination attempts have not resulted in you becoming immune:** Should you believe that you fall into this category you will need to provide documented evidence of your vaccination course completion and your immunity status consistent with the requirements listed above.

EMPLOYMENT HEALTH ASSESSMENT

Please note: The information provided will be treated in the strictest confidence

General Information and instructions

SWIAA Village is committed to ensure that all prospective employees satisfy the inherent job requirements

and job demands of the position for which they are being considered and that all employees are safe in fulfilling this role. You are therefore required to:

1. PRINT CLEARLY
2. Complete Assessment form and place in the sealed envelope provided and bring with you to the interview.
3. You must complete all questions – if insufficient space please attach separate sheets/s of paper
4. Please attach any required documents and/or evidence and any other supporting documents

<i>INFORMATION PROVIDED WILL BE TREATED AS CONFIDENTIAL (PLEASE PRINT)</i>				
Title: (please tick)	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Ms <input type="checkbox"/>
Gender: (please tick)	Male <input type="checkbox"/>		Female <input type="checkbox"/>	Other <input type="checkbox"/>
Surname:				
Given Names:				
Former Names: (if applicable)				
Address:				
Date of Birth:				
Home/Private Number:		Mobile Number:		
Position Applied for:				

YOU MUST COMPLETE ALL QUESTIONS (please tick response)

1) Have you had previous work related injuries? Yes ☐ No ☐

1a) Please list details, of previous work related injuries and any Workers' Compensation Claims relate to those injuries:

Date of Injury	Nature of Injury/Illness	Medical Treatment	Employer	Insurer

1b) Please indicate if your Workers' Compensation Claim is closed Yes ☐ No ☐ NA ☐

- 2) Have you been involved in any motor vehicle accidents resulting in personal injury?
Yes ☐ No ☐

2a) Please list details of motor vehicle accidents or 3rd Party claims relating to injuries sustained:

Date of Injury	Nature of Injury/Illness	Medical treatment	Insurer

- 3) Have you suffered back pain or strain injury? (Including back surgery) Yes ☐ No ☐
If yes, please give details.

- 4) Have you suffered from shoulder, neck or arm strain? Yes ☐ No ☐
If yes, please give details.

- 5) Have you had a full medical clearance for any injuries identified in questions 1,2,3, or 4? Yes ☐ No ☐ If yes, please give details.

- 6) Are you receiving any ongoing treatment for injuries identified in questions 1, 2, 3 or 4?
Yes ☐ No ☐ NA ☐ If yes, please give details.

- 7) Do you suffer from any medical condition (including physical, psychiatric/psychological) for which you are receiving treatment? Yes ☐ No ☐ If yes, please give details.

- 8) Do you have an impairment, disability or handicap of any type? Yes ☐ No ☐
If yes, please give details.

- 9) Have you ever suffered from or had: *(please tick appropriate answer)*

Asthma/bronchitis/pleurisy	yes <input type="checkbox"/>	no <input type="checkbox"/>	Allergies	yes <input type="checkbox"/>	no <input type="checkbox"/>
Persistent cough/shortness of breath	yes <input type="checkbox"/>	no <input type="checkbox"/>	Hernias	yes <input type="checkbox"/>	no <input type="checkbox"/>
Tuberculosis	yes <input type="checkbox"/>	no <input type="checkbox"/>	Psychiatric/psychological	yes <input type="checkbox"/>	no <input type="checkbox"/>
Heart trouble/chest pain	yes <input type="checkbox"/>	no <input type="checkbox"/>	Severe anxiety/depression	yes <input type="checkbox"/>	no <input type="checkbox"/>
High or low blood pressure / dizzy spells	yes <input type="checkbox"/>	no <input type="checkbox"/>	Head injury	yes <input type="checkbox"/>	no <input type="checkbox"/>
Haemophilia/any blood disease	yes <input type="checkbox"/>	no <input type="checkbox"/>	Persistent headaches/migraines	yes <input type="checkbox"/>	no <input type="checkbox"/>
Epilepsy/fits	yes <input type="checkbox"/>	no <input type="checkbox"/>	Broken bones	yes <input type="checkbox"/>	no <input type="checkbox"/>
Diabetes	yes <input type="checkbox"/>	no <input type="checkbox"/>	Torn cartilages	yes <input type="checkbox"/>	no <input type="checkbox"/>
Arthritis/rheumatism	yes <input type="checkbox"/>	no <input type="checkbox"/>	Ear problems/hearing loss	yes <input type="checkbox"/>	no <input type="checkbox"/>
Tenosynovitis/carpal tunnel/RSI	yes <input type="checkbox"/>	no <input type="checkbox"/>	Any eyesight problems	yes <input type="checkbox"/>	no <input type="checkbox"/>
Sciatica	yes <input type="checkbox"/>	no <input type="checkbox"/>	Do you wear glasses/lenses	yes <input type="checkbox"/>	no <input type="checkbox"/>
Wrist or elbow pain/weakness	yes <input type="checkbox"/>	no <input type="checkbox"/>	Any other serious illness	yes <input type="checkbox"/>	no <input type="checkbox"/>
Scars/deformations which may restrict physical movement	yes <input type="checkbox"/>	no <input type="checkbox"/>	Are you using a mobility aid	yes <input type="checkbox"/>	no <input type="checkbox"/>
Skin trouble/dermatitis	yes <input type="checkbox"/>	no <input type="checkbox"/>	Kidney disorders/urinary tract infection	yes <input type="checkbox"/>	no <input type="checkbox"/>

If you answered 'yes' to any of the above provide further details below:

10) Protection Against Specific Vaccination Preventable Infectious Diseases

In accordance with the NSW Health Policy PD 2007_006 "Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases", all new employees are to provide acceptable evidence of protection against the specified infectious diseases.

Applicants are advised that an offer of employment will not be made until acceptable evidence of protection against the specified infectious diseases has been provided

If you respond 'yes' to any of the following questions, you will need to support these responses with evidence. This specific evidence required is outlined in the section: "Evidence of Protection against Specified Infectious Diseases" Please refer to this section prior to answering as this may assist you.

If you responded 'no' to any of the following questions, you will be required to provide acceptable evidence prior to being made an offer of employment. Therefore, it is strongly recommended that you attend an immunisation provider and have your vaccinations and/or immunity status upgraded to ensure you meet the required 'level of protection'.

Please tick your response to the following questions

a) Have you completed a vaccination course for?

Disease			
Hepatitis B	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
Measles	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
Varicella (Chicken Pox)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
Mumps	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
Rubella (German Measles)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>

If you answered 'no to any of the above, did you do so because vaccination is contraindicated for you?

Yes ☐ No ☐

If you answered 'unsure', do you have any comments you would like to make?

b) Have you during your adult life (that is 14 years of age or older) been vaccinated for?

Disease			
Diphtheria	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
Tetanus	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
Pertussis (Whooping cough)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>

If you answered 'no to any of the above, did you do so because vaccination is contraindicated for you?

Yes ☐ No ☐

If you answered 'unsure', do you have any comments you would like to make?

c) Are you immune to the following diseases?

Disease			
Hepatitis B	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
Measles	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
Varicella (chicken Pox)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
Mumps	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
Rubella (German Measles)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>

Yes ☐ No ☐

Yes ☐ No ☐ Unsure ☐

Yes ☐ No ☐

Have you had a TST in the last 12 months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is TST or Mantoux testing contraindicated for you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had a Chest X-ray within the last 12 months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Yes ☐ No ☐

If you responded 'yes' to any of the following questions, you will need to support these responses with evidence. The specific evidence required is outlined in the section "Evidence of Protection against Specified Infectious Diseases". Please refer to this section prior to answering as this may assist you.

If you responded 'no' to any of the following questions, you will need to provide acceptable evidence prior to being made an offer of employment. Therefore, it is strongly recommended that you attend an immunisation provider and have your vaccinations and/or immunity status upgraded to ensure you meet the required 'level of protection'

I understand that I may be required to undergo a medical and/or psychiatric assessment

Yes ☐ No ☐

I declare that to the best of my knowledge and belief, all the information I have provided is true and correct. I am aware that false or misleading statements may affect my appointment or continued employment

/ /

THANK YOU FOR COMPLETING THIS FORM