

**APPLICATION FOR EMPLOYMENT**

1. **PERSONAL DETAILS**

NAME:

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|  |

ADDRESS:

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|  |

POSTCODE:

|  |
| --- |
|  |

TELEPHONE

|  |  |
| --- | --- |
| HOME:  | MOBILE: |

DATE OF BIRTH:

|  |
| --- |
|  |

MARITAL STATUS:

|  |
| --- |
|  |

CHILDREN (IF YES HOW MANY) :

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|  |

1. **DRIVING LICENSE DETAILS**

DO YOU HOLD A CURRENT DRIVING LICENSE FOR ANY OF THE BELOW:

|  |  |
| --- | --- |
| B MOTOR VEHICLE UPTO 3.5 TONNE |  |
| C1 MEDIUM GOOD VEHICLE BETWEEN 3.5 - 7.5 TONNES |  |
| C LARGE GOOD VEHICLE OVER 7.5 TONNES |  |
| C+E LARGE GOODS VEHICLE OVER 18 TONNES DRAWING A TRAILER |  |

PLEASE DETAIL ANY PENALTY POINTS INCLUDING NATURE OF OFFENCE:

|  |
| --- |
|  |

WHICH TYPE OF DRIVING LICENSE DO YOU HOLD:

|  |  |
| --- | --- |
| B MOTOR VEHICLE UPTO 3.5 TONNE |  |
| C1 MEDIUM GOOD VEHICLE BETWEEN 3.5 - 7.5 TONNES |  |
| C LARGE GOOD VEHICLE OVER 7.5 TONNES |  |
| C+E LARGE GOODS VEHICLE OVER 18 TONNES DRAWING A TRAILER |  |

DO YOU HOLD ANY OF THE FOLLOWING

|  |  |
| --- | --- |
| CDG ROAD LICENSE (HAZ-CHEM) |  |
| COUNTER BALANCE FORK LICENSE |  |
| REACH TRUCK FORK LIFT LICENSE |  |
| BENDI FORK LIFT LICENSE |  |

PLEASE GIVE DETAILS OF ANY VEHICLE ACCIDENTS WITHIN THE LAST 5 YEARS

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|  |

 **3. EMPLOYMENT RECORD**

**PRESENT OR MOST RECENT EMPLOYMENT**

NAME AND ADDRESS OF EMPLOYER:

|  |
| --- |
|  |

|  |  |
| --- | --- |
| **JOB:** | **LENGTH OF SERVICE:** |
| **HOURLY RATE:** | **NOTICE REQUIRED:** |

SUMMARY OF YOUR DUTIES AND RESPONSIBILITIES RELATED TO THE ABOVE JOB:

|  |
| --- |
|  |

PREVIOUS EMPLOYMENT

|  |  |  |
| --- | --- | --- |
| **NAME AND ADDRESS OF EMPLOYER** | **LENGTH OF SERVICE** | **JOB TITLE AND MAJOR ELEMENTS OF THE JOB** |
|  |  |  |

1. **EDUCATION AND TRAINING**

SECONDARY EDUCATION

|  |  |  |
| --- | --- | --- |
| **CERTIFICATES GAINED** | **SUBJECTS/MODULES** | **GRADES/BANDS** |
|  |  |  |

FURTHER AND HIGHER EDUCATION

|  |  |  |
| --- | --- | --- |
| **WHERE ATTENDED** | **COURSE (SHOW FULL OR PART TIME)** | **QUALIFICATIONS AND DATE GAINED** |
|  |  |  |

OTHER TRAINING - RELEVANT TO THIS APPLICATION

|  |  |  |
| --- | --- | --- |
| **NAME OF COURSE** | **PROVIDED BY** | **DURATION** |
|  |  |  |

PROFESSIONAL QUALIFICATIONS

|  |  |  |
| --- | --- | --- |
| **NAME OF PROFESSIONAL BODY** | **CLASS OF MEMBERSHIP** | **DATE OBTAINED** |
|  |  |  |

 **5. SUPPLEMENTARY INFORMATION**

GIVE ANY FURTHER DETAILS OF YOUR EXPERIENCE WHICH YOU CONSIDER RELEVANT

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| --- |
|  |

 **6. CRIMINAL CONVICTIONS**

IF YOU HAVE PREVIOUSLY BEEN CONVICTED OF ANY OFFENCES, PLEASE PROVIDE DETAILS BELOW UNLESS THE CONVICTION CAN BE REGARDED AS “SPENT” IN TERMS OF THE REHABILITATION OF OFFENDERS ACT 1974

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| --- |
|  |

**7. REFERENCES**

Please name two referees, at least one of whom should have direct knowledge of your work experience and abilities.

|  |  |
| --- | --- |
| **NAME** |  |
| **ADDRESS** |  |
| **TEL NUMBER** |  |
| **OCCUPATION** |  |

|  |  |
| --- | --- |
| **NAME** |  |
| **ADDRESS** |  |
| **TEL NUMBER** |  |
| **OCCUPATION** |  |

|  |  |
| --- | --- |
| **DO YOU WISH TO BE NOTIFIED BEFORE CONTACTING THESE REFERENCES?** |  |

**HEALTH/MEDICAL INFORMATION**

As per of your application for employment we require you to complete the attached questionnaire.

**DECLARATION**

|  |
| --- |
| I verify that to the best of my knowledge, the information supplied by me on this application form, and on any additional sheets is correct.SIGNATURE:DATE: |

1. **MEDICAL QUESTIONNAIRE**

MEDICAL QUESTIONNAIRE for completion by all applicants and employees.

The information you provide on this form will be kept entirely confidential. It is required to enable us to ensure your safety and the safety of others. If you are not clear on any points these can be discussed at your initial interview.

It is essential that the form is completed honestly and fully. Applicants must hand it in not later than your initial interview as a decision on your application cannot be made until we have seen the complete form.

|  |  |
| --- | --- |
| Surname: | First Name(s): |
| Date of Birth: | Date of Initial interview: |

**MEDICAL HISTORY**

Please indicate if any of the following apply or have applied to you in the past by marking (X) Yes or No in the box, as appropriate, to all 22 section. Failure to (X) any section will be regarded as a “yes” response. Minor problems, eg: minor injuries - should be ignored

 **YES NO**

|  |  |  |
| --- | --- | --- |
| 1. **Circulatory problems - e.g. varicose veins, phlebitis thrombosis, numbness?**
 |  |  |
| 1. **Heart problems; e.g: angina, heart murmur, heart attack?**
 |  |  |
| 1. **High blood pressure?**
 |  |  |
| 1. **Chest problems; e.g: Asthma, Breathless?**
 |  |  |
| 1. **Diabetes?**
 |  |  |
| 1. **Epilepsy or fainting attacks?**
 |  |  |
| 1. **Psychiatric or psychological problems?**
 |  |  |
| 1. **Skin disorders?**
 |  |  |
| 1. **Operation or fracture within the last 5 years?**
 |  |  |
| 1. **Alcoholism or drug abuse?**
 |  |  |
| 1. **Back trouble, arthritis, rheumatism?**
 |  |  |
| 1. **Trouble with bones, joints, tendons, including wrist tendons?**
 |  |  |
| 1. **Repetitive strain injury ?**
 |  |  |
| 1. **Problems with eyesight or hearing?**
 |  |  |
| 1. **Migraine or persistent headaches?**
 |  |  |
| 1. **Stress or stress related problems?**
 |  |  |
| 1. **Other significant health problems?**
 |  |  |
| 1. **Have you worked in an industry with high noise levels?**
 |  |  |
| 1. **Have you ever been found medically unfit to work?**
 |  |  |
| 1. **Have you ever claimed for industrial or other injury, disease or illness?**
 |  |  |

|  |  |  |
| --- | --- | --- |
| 1. **Are you now on any medication?**
 |  |  |
| 1. **Have you been on medication in the past 5 years?**
 |  |  |
| **If you have ticked “Yes” to any of the above please provide details here:** |  |  |

|  |
| --- |
| I hereby declare that the above information is correct to the best of my knowledge.SIGNATURE:DATE: |