126 Churchill Road North,
Dry Creek SA 5094
Ph: (08) 8360 2379 | Fax: (08) 8266 9338
Email: jobs@natwidepersonnel.com.au

EXPRESSIONS OF INTEREST FOR EMPLOYMENT

PERSONAL DETAILS					
First Name		Last Name			
DOB		Age			
Mobile No.		Email			
Address					
Drivers Licence No		Expiry Date			
No. of demerit points left		Job Network			
What transport do you have to & from work?					
Licences & Certificates (White Card, Forklift etc.)					
Will you pass a D&A Test?	YES NO	Currently on any medication?	YES NO		
Please explain ^^ if No					
Do you smoke?	YES NO	How many per day approximately?			
Do you drink alcohol	YES NO	How many drinks per day approximately?			
Have you ever lost your licence?	YES NO	Reason			
Are you willing to obtain a Driver History Report?	YES NO				
Are you seeking:	Full Time	Casual	Part Time		
Position applying for? (forklift, truck driving, labouring)					
Hourly Rate desired?		Salary Expectation?			
Available start date		Days Available to work	Mon Tue Wed Thur Fri Sat Sun ALL		
Current | Previous Role					
Dates employed	To:	From:			
Role | Duties					
Reason for leaving					
Do you have any existing or pre-existing injuries? *If YES, please explain..*					
Are you physically fit & able to do heavy lifting or repetitive work?					
Current resume attached	YES NO	*If No, please complete overside form…PAST EMPLOYMENT DETAILS*			
Anything you would like to tell us about yourself:					

Candidate Signature	

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PAST EMPLOYMENT DETAILS

Current | Previous Role		
Dates employed	To:	From:
Role | Duties	- - - - -	
Reason for leaving		

Current | Previous Role		
Dates employed	To:	From:
Role | Duties	- - - - -	
Reason for leaving		

Current | Previous Role		
Dates employed	To:	From:
Role | Duties	- - - - -	
Reason for leaving		

Current | Previous Role		
Dates employed	To:	From:
Role | Duties	- - - - -	
Reason for leaving		

WORK REFERENCES *[PLEASE SUPPLY MINIMUM 2 REFERENCES]*

REFERENCE NAME	REFERENCE PHONE NUMBER

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Natwide Personnel
'CONFIDENTIAL MEDICAL ASSESSMENT'

Some work may require physical labour intensive work, or expose you to a variety of hazards or risks. We need to be aware of any condition to avoid an aggravation or risk that condition. The medical information is NOT designed to exclude you from employment.

Surname: _____ Other Names: _____

1. Have you ever been treated for?

	Yes	No		Yes	No		Yes	No
Back Injury	☐	☐	Migraine	☐	☐	Ear Problems	☐	☐
Neck Injury	☐	☐	Nervous Disorder	☐	☐	Tinnitus	☐	☐
Shoulder Injury	☐	☐	Stress	☐	☐	High Blood Pressure	☐	☐
Arm Injury	☐	☐	Depression	☐	☐	Eye Pressure	☐	☐
Wrist Injury	☐	☐	Anxiety	☐	☐	Rheumatism / Arthritis	☐	☐
Hand Injury	☐	☐	Skin Problems	☐	☐	Back Aches	☐	☐
Leg Injury	☐	☐	Asthma	☐	☐	Epilepsy / Fits	☐	☐
Foot Injury	☐	☐	Hay Fever	☐	☐	Dermatitis / Eczema	☐	☐
Other Bone Injury	☐	☐	Heart Disease	☐	☐	Head / Concussion	☐	☐

If yes, please detail: . . . . . .

Is the condition current: *YES / NO* Period of treatment: . . . . . .

Does the condition restrict you in any way? *YES / NO*

If yes, please detail under what circumstances:

. . . . . .

2. Have you ever been excessively exposed to:

	Yes	No		Yes	No
Dust	☐	☐	Skin Irritants	☐	☐
Chemicals	☐	☐	Ionising Radiation	☐	☐
Noise	☐	☐	Other Environmental Hazards	☐	☐
Toxic Metals	☐	☐			

Does exposure / contact with any of the above give you a rash, cause breathing difficulties, or cause any other problems?

If yes, please detail: . . . . . .

3. Do you have any condition or illness which precludes you from doing any particular type of work?

	Yes	No		Yes	No
Alcohol or Drug	☐	☐	Confined Space	☐	☐
Loss of Mobility	☐	☐	Hearing Difficulty	☐	☐
Dizziness at Heights	☐	☐	Vision Impairment	☐	☐
Psychological Problems	☐	☐	Any other condition	☐	☐

If yes, please detail: .....

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4. Have you ever had trouble with wearing any safety equipment, including gloves, eye / ear protection or any other protective equipment? YES / NO

If yes, please detail: . . . . . .

5. Do you suffer from any allergies? YES / NO

If yes, please detail: . . . . . .

6. Are you currently on any regular medical treatment or medication? YES / NO

If yes, please detail: . . . . . .

7. Have you ever had a heart condition? YES / NO

If yes, please detail: . . . . . .

8. Have you ever had a blood pressure problem? YES / NO HIGH / LOW

If yes, please detail: . . . . . .

9. Have you ever been advised to change jobs for medical reasons? YES / NO

If yes, please detail: . . . . . .

10. Have you ever been advised to slow down or reduce your activities? YES / NO

If yes, please detail: . . . . . .

11. Have you ever had time off work due to any injury? YES / NO

If yes, please detail: . . . . . .

12. Have you ever suffered from RSI, OSS, or wrist problem, Tennis Elbow or Tendonitis? YES / NO

If yes, please detail: . . . . . .

13. Do you have any condition or illness which effects the way you perform tasks or precludes you from doing any particular type of work? YES / NO

If yes, please detail: . . . . . .

14. Have you ever suffered from any spinal, disc or back problem? YES / NO

If yes, (a) What and when were the circumstances:

(b) What treatment did you receive:

(c) What residual problems do you have:

15. Have you ever had a neck problem? YES / NO

If yes, (a) How often does this occur: . . . . . .

(b) When was the last time it occurred: . . . . . .

(c) What causes or aggravates it: . . . . . .

(d) What treatment do you receive: . . . . . .

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16. Have you ever had a work related injury? YES / NO

If yes, (a) When did this occur: . . . . . .

(b) What injury did you sustain: . . . . . .

(c) What residual problem do you have: . . . . . .

(d) Did you lodge a claim: . . . . . .

17. Have you ever been exposed to excessive noise? YES / NO

If yes, please detail: . . . . . .

18. Have you ever had your hearing tested? YES / NO

If yes, please detail: . . . . . .

19. Have you ever had a car accident? YES / NO

If yes, (a) When did this occur: . . . . . .

(b) Did you suffer any injuries: . . . . . .

(c) What residual problems do you have: . . . . . .

20. Do you engage in regular exercise? YES / NO

If yes, what type: . . . . . .

21. Do you smoke? YES / NO

If yes, how many per day: . . . . . .

22. Do you drink alcohol? YES / NO

If yes, how many glasses per week: . . . . . .

23. When was your last tetanus injection? . . . . . .

24. When was your last Hepatitis B injection? . . . . . .

25. Is there anything else we should know about? (please detail) . . . . . .

. . . . . .

. . . .

I certify the above responses are correct to the best of my knowledge and any deliberate incorrect answers may lead to my employment being terminated. I give permission for this information to be verified with my treating practitioner(s).

Family / Treating Doctor:

Name: . . . . . .

Address: . . . . . .

Applicants Signature: _____ Date: _____