Condello's Liquor Stores

Application for Employment

All applications must be accompanied with a:

- **Responsible Service of Alcohol certificate.**
- **Drivers License (Current)**
- **Police clearance (Current)**

Proceeding will not go forward without these certificates.

Position applied for:

Surname:	First Name:
Address:	
Home phone:	Mobile Number:
Date of birth:	

In case of an emergency notify:	
Name & Address:	Hm Phone: Mobile:
Relation:	

Physical / Health Histroy

IMPORTANT
Section 79 of the Workers Compensation and Rehabilitation Act 1981
"Where it is proved that a worker has, at the time of seeking or entering employment in respect of which he/she claims compensation for a disability, wilfully and falsely represented themselves as not having previously suffered from a disability, a dispute resolution body may in its discretion refuse to award compensation which otherwise would be payable."

Applicant to complete: *(please circle your answer, these may be disussed further)*			If yes, please explain
Are you required to take medication which may affect your work performance?	Yes	No	
Are you required to take medication which may affect your attendance at work?	Yes	No	
Are you willing to take a medical examination?	Yes	No	
Are you willing to take a random alcohol and other drug tests?	Yes	No	
Have you have time off work in the last year for illness or injury?	Yes	No	
Are you currently being treated by a doctor for any illness or injury?	Yes	No	
Have you had an injury or illness which may impact on your ability to do the job?	Yes	No	
Have you had a current Workers Compensation claim?	Yes	No	
Do you or have you ever had back, neck, shoulder, knee or joint problems?	Yes	No	
Is there any reason why you cannot wear safety or protective equipment?	Yes	No	
Have you have a Tetanus injection in the last ten years?	Yes	No	
Have you ever been refused Life Insurance, Disability Insurance, Employment or Miltary Service?	Yes	No	
Are you affected by heights or confined spaces?	Yes	No	
Know Alergies Medications Foods Other (specify)	Yes	No	

Place an X in the box beside any condition(s) you have or had at any time in your life.	
o Blood Pressure	o Repetitive strain / overuse injury
o Lung problems / Asthma	o Arthritis / Rheumatism
o Tuberculosis	o Mental or nervous troubles
o Hernia	o Loss of hearing or ear infections
o Fits / Seizures / Blackouts	o Visual Impairments
o Persistent headaches / Migraines	o Stomach problems / Ulcers
o Diabetes (sugar)	o Hepatitis / Jaundice / Liver trouble
o Any joint problems / fractures	o Skin disorders / Dermatitis
o None of the above	
Please comment on all those marked with an X (use the back of this sheet if necessary)	

Place an X in the box beside each activity with which you have difficulty		
o Running 100 metres	o Climbing a ladder	o Walking on rough ground
o Crouching	o Kneeling	o Sitting for two hours
o Standing for two hours	o Lifting or bending	o Turning your head rapidly
o Gripping firmly with both hands	o Using hand tools	o Repetitive Movements of the hands or arms
o Hearing a normal conversation	o Reading ordinary print	o Concentrating on what you are doing
o Understanding English		
Please comment on those marked with an X		

Have you had any exposure to the following in your past employment?			
			If yes please give details
Loud noise / explosives / gunfire	Yes	No	
Asbestos	Yes	No	
Chemicals	Yes	No	
Radiation	Yes	No	
Dust	Yes	No	

Details of previous employment

Dates	Company	Position	Duties	Reason for leaving

Have you been previously employed by this company? Yes No

List three professional referees:

Name	Company	Address	Position	Phone

Drivers Licence Nº	State	Class	Expiry Date

Please list any certificates or training you have or are undertaking

Declaration

I solemnly declare that each and every answer above is true to the best of my knowledge and belief. I understand that any false or misleading information may result in termination of employment. I understand that I may also be required to undergo baseline health test on termination of employment.

Statement Authorisation

I hereby authorise the examining doctor to submit a medical report regarding the above statement, physical findings, audiogram and all other investigations to my employer.

Applicant's signature:		**Date:**	

Election of Preferred Hours

	Tick Preferred Hours
Monday – Friday 9am – 5pm	
Monday – Friday 5pm – 8.30pm	
Saturday 9am – 5pm	
Saturday 5pm to 8:30pm	
Sunday	
Public Holidays	
Additional Hours	

Employee's signature:		**Date:**	

Employer's signature:		**Date:**	

Signed by or on behalf of the employer, CLS Pty Ltd

Signature	Position
Print Name	Date