

# Application for Employment (Office)

Please complete this form in as much detail as you can, as it will assist us in our assessment and improve your chances of successful employment and correct placement.

## Section 1

1. Date: \_\_\_\_\_ 2. Position Sought: \_\_\_\_\_

3. Surname: \_\_\_\_\_ Other Names: \_\_\_\_\_

4. Address: \_\_\_\_\_ Phone: \_\_\_\_\_

5. Date of Birth: \_\_\_\_\_ 6. Age: \_\_\_\_\_

7. Next of kin (person to be notified in case of an emergency):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

10. Present Employer: \_\_\_\_\_

11. Previous Employment: *please list details of most recent jobs first*

Name of Employer	Employer Phone No.	Period of Employment From To	Job Title or Position	Reason for Leaving

12. Work Experience: *Briefly describe the nature and extent of previous experience  
e.g. type of jobs worked on, nature of work done etc.*

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*Please circle the CORRECT answer*

May we contact your previous employers for a reference?

YES

NO

Are you member of:

Number *(please write membership number)*

_____	_____
_____	_____
_____	_____
_____	_____

OTHER SUPERANNUATION OR  
REDUNDANCY FUND

\_\_\_\_\_

Medical History:

*You are requested to carefully consider your responses to these questions. The Company and you are both subject to stringent legal requirements pursuant to the Occupational Health, Safety and Welfare Act 1986 (S.A.) with respect to avoiding putting workers at risk. Failure to complete this section truthfully and completely may lead to instant termination of employment.*

**Do you have, or have you had, any of the following diseases or conditions?**

Eye Disorder, trouble or problems with vision	YES	NO
Nasal trouble, sinus trouble	YES	NO
Ear disorder, deafness	YES	NO
Allergies	YES	NO
Skin trouble (dermatitis, eczema etc.)	YES	NO
Asthma	YES	NO
Heart disease or defect	YES	NO
Hernia (rupture)	YES	NO
Back problems	YES	NO
Diabetes	YES	NO
Dizziness, epilepsy or fits	YES	NO
Nervous or mental disorder	YES	NO
Back injury or strain	YES	NO
Shoulder injury or strain	YES	NO
Alcoholism or drug dependence	YES	NO
Spinal disorder, damaged discs	YES	NO
Any other disease, physical or mental injury	YES	NO

If YES, give brief details:

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Attach extra sheets if necessary

DECLARATION

I agree that the above questions are fully understood by me and that the answers stated are true to the best of my knowledge, and if employed I undertake to observe all safety regulations and instructions from the employer.

I acknowledge that I will submit to drug and alcohol testing as part of my job application process and as required by the employer or its customers or clients at any time in the future.

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

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EMPLOYER SECTION

Award wage: \_\_\_\_\_ Wage: \_\_\_\_\_

Date started: \_\_\_\_\_

Comments:

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