

EMPLOYMENT HISTORY

Most recent first)

Organisation Name	Ward/ Unit	Report to Name	Tel No.	Date Begun (MM/YY)	Date Finished (MM/YY)	Reason for leaving

REFEREES

Name:	Name:
Title	Title
Phone:	Phone:
Email:	Email:

EMPLOYMENT AUTHORISATION

I hereby acknowledge that I have read/viewed and understand the following Staff Australia Pty Ltd policies and procedures and agree to adhere to all condition within.
(Please initial each box)

INDUCTION PRESENTATION

- Types of work available
- Availability
- Punctuality & Reliability
- Personal Protective Equipment
- Assignment Feedback
- Explanation of Staff Australia
- Payroll Services
- Workplace Health & Safety
- What To Do If You Are Injured

INDUCTION BOOKLET

- Bullying, Harassment & Occupational Violence (page 9)
- Alcohol & Drugs Policy (page 10)
- Workplace Health & Safety Policy (page 11)
- Injury Management Policy (page 13)
- Privacy Policy (page 15)
- Contractor Employment Agreement (page 17)

I acknowledge that all information is true and correct, and any deliberate falsification will result in my immediate termination of employment with Staff Australia Pty Ltd. I also agree to Staff Australia Pty Ltd & it's clients to conduct reference checks and security checks deemed necessary to determine my suitability for employment with Staff Australia Pty Ltd and to contact those referees, subsequent to my employment, as and when deemed necessary.

I confirm the information I have given in the Health section of this form is correct, and I acknowledge that if I have failed to make a disclosure, then any recurrence, aggravation, acceleration, exacerbation or deterioration of the pre- existing injury, condition or disease arising out of or in the course of or due to the nature of employment with Staff Australia Pty Ltd may not entitle me to compensation under the Accident Compensation Act VIC 1985.

I have read and understood all conditions contained herein.

FULL NAME: _____ **SIGNATURE:** _____ **DATE:** ___/___/___

STAFF AUSTRALIA REPRESENTATIVE: _____ **SIGNATURE:** _____ **DATE:** ___/___/___



CANDIDATE APPLICATION DETAILS

Date: _____

PERSONAL DETAILS

GIVEN NAMES: _____ SURNAME: _____

Preferred Name: _____

GENDER: MALE / FEMALE (Please Circle)

DATE OF BIRTH: / /

RESUME ATTACHED Yes / No

CONTACT INFORMATION:

HOME: _____ MOBILE: _____ OTHER: _____

DO NOT PHONE BEFORE: _____ DO NOT PHONE AFTER: _____

ADDRESS: _____

SUBURB: _____ STATE: _____ POSTCODE: _____

In order to supply your weekly pay information & protect our environment. Staff Australia will email your payslip. Please provide your email address below.

EMAIL ADDRESS: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP: _____

CONTACT NUMBER: _____

PAYROLL DETAILS

TAX FILE NUMBER: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ (MUST BE 9 DIGITS)

NAME OF BANK: _____ BANK LOCATION: _____

ACCOUNT NAME: _____

BSB NUMBER: ___ ___ ___ / ___ ___ ___ (MUST BE 6 DIGITS) ACCOUNT NUMBER: ___ ___ ___ ___ ___ ___ ___ (MAX 9 DIGITS)

WORK RIGHT DETAILS

WERE YOU BORN IN AUSTRALIA? YES / NO (IF NOT, PLEASE ANSWER THE FOLLOWING QUESTIONS)

COUNTRY OF BIRTH: _____

HAVE YOU BECOME AN AUSTRALIAN CITIZEN? YES / NO (IF YES, PLEASE PROVIDE COPY OF CITIZENSHIP CERTIFICATE)

IF NOT, PLEASE PROVIDE YOUR PASSPORT DETAILS BELOW: (COPY OF PASSPORT REQUIRED)

PASSPORT NUMBER: _____ COUNTRY OF PASSPORT: _____

PASSPORT EXPIRY: _____ OFFICE USE ONLY: VEVO CHECK COMPLETED

AVAILABILITY

ARE YOU IDEALLY INTERESTED IN? CASUAL CONTRACT/ONGOING PERMANENT

WHAT SHIFTS ARE YOU AVAILABLE FOR? DAY AFTERNOON NIGHT WEEKENDS

AVAILABLE FROM: IMMEDIATELY OR ENTER DATE: _____ HOLIDAYS REQUIRED: _____

MEDICAL HISTORY/VACCINATION FORM

OCCUPATIONAL SCREENING AND VACCINATION OF HEALTH CARE WORKERS AGAINST INFECTIOUS DISEASES

Please read the following information and complete the questionnaire.

The current QLD Workplace Health and Safety Act requires employers to ensure the health, safety and welfare at work of all employees. Under this Act, employees must also take reasonable care of the health and safety of people in their workplace. Employees are obliged to co-operate with employers in meeting their OH&S obligations.

Staff Australia is committed to ensuring the health and safety of all patients in health care settings and providing a safe and healthy working environment for all health care workers. To this end we have adopted a policy requiring all health care workers to have documented evidence of their status regarding the diseases/illnesses below. Health care workers have the right to non-participation in screening and vaccination programs but must acknowledge their non-participation and understanding of any risks consequent upon non-participating in writing.

If you answer 'yes' to any of the questions below, please provide details.

Do you have any pre-existing injuries that place restrictions on you at work? _____

Have taken 2 weeks medical leave from work in the last 2 years? _____

Are you currently taking medications or drugs including inhalers? _____

Are you currently being treated by any doctor for any illness? _____

Are you unable to utilise personal protective equipment? _____

Are you allergic to anything? (If yes, give details) _____

Do you now, or have you ever, suffered from any of the following? (If yes please tick box and give details below)

- Tuberculosis
- Wheezing/asthma
- Heart trouble/chest pain
- Hernia
- Back, Neck or Spinal problems
- Mental/Nervous disorder
- Fits/Epilepsy
- Diabetes
- HIV
- Dermatitis/eczema/psoriasis
- Loss of hearing
- Arthritis
- Other Illness
- Rheumatic fever

Details _____

MEDICAL HISTORY/VACCINATION FORM

VACCINATIONS

TYPE	YES	NO	PROOF SUPPLIED
Hepatitis B (proof must be supplied of Hep B)			
Polio			
Tetanus			
Whooping Cough			
MMR (combined)			
Measles			
Mumps			
Rubella			
Chicken Pox			
Other			

TUBERCULOSIS:			
	Date	Where	Status
BCG Immunisation			Yes / No
Mantoux Test			Positive / Negative
Chest X-Ray			Result:
Hibtitier Vaccine			

DECLARATION BY APPLICANT

Are you aware of the physical requirements of nursing? Yes No

Do you have any physical limitations that would impact on the above? Yes No

I declare:

That the answers to the foregoing are to the best of my knowledge true and correct in every particular;

That if my application to register is successful, I will be bound by and at all times observe and respect such terms and conditions of my employment and such policies and rules as may from time to time be promulgated, specified, or otherwise stipulated by the Agency.

Signature of Applicant _____ Print Name _____

Interviewer/Witness _____ Print Name _____

Date _____