



IN CONFIDENCE

APPLICATION FOR EMPLOYMENT

Surname:

Given Name(s): Previous Surname:

Residential/Postal Address:

State: Post Code:

Date of Birth: Gender: Male Female

Telephone Numbers: Home: () Mobile:

E-mail address: @

Next of Kin: Relationship:

Address:

Telephone Numbers: Home: () Work: ()

Title of Position Applied for:

Have you previously been employed by this Health Service? Yes No

If Yes,

What dates: ___/___/___ to ___/___/___ Position:

Do you have other employment that you intend to maintain if successful in this application?

Yes No

If Yes, please give details:
.....

Have you been reported/referred to the Health Services Commissioner (Vic), the Health Care Complaints Commission (NSW) or any other similar Health Complaints Commission in any of the other States/Territories in Australia?

Yes No

If Yes, please give details:
.....

Are you an Australian Citizen? Yes No

If No, Do you have Permanent Australian Residency Status? Yes No

If No, On what basis are you able to apply for employment with our Healthcare Facility?

.....

What is your Visa Type: Visa Expiry Date: ___/___/___

Passport Number:
 (Please provide a certified copy of your passport/Visa status)

Education/Qualifications *Include: Basic and Post Basic Education*
 (Please attach a copy of ALL relevant documentation)

Title	Started	Finished	Institution	Exams Passed

Employment History *Include last 5 positions held (most recent first)*

Dates	Employer	Position Held	Reason for Leaving
___/___/___ To ___/___/___	Full Time/Part Time/Casual	If Part time: How many hours/fn? _____	
___/___/___ To ___/___/___	Full Time/Part Time/Casual	If Part time: How many hours/fn? _____	
___/___/___ To ___/___/___	Full Time/Part Time/Casual	If Part time: How many hours/fn? _____	
___/___/___ To ___/___/___	Full Time/Part Time/Casual	If Part time: How many hours/fn? _____	
___/___/___ To ___/___/___	Full Time/Part Time/Casual	If Part time: How many hours/fn? _____	

Please attach a separate sheet if required.

Practising Certificates and Registrations:

Nurses Board of Victoria

Allied Health Registration

Receipt/Registration No.:

Expiry Date: ___/___/___

Name of Registration Board:

Type: RN Div1 / RM / Div 2 ME / Div 2 / Div 3 / Allied Health

Have you been reported/referred to your relevant Professional Registration Body for disciplinary action?

Yes

No

If Yes, please provide details (including outcome if known):

.....

NSW Practising Certificate

Receipt/Registration No.: Type: RN – List A Expiry Date: ___/___/___

Membership of Professional Bodies:

.....

.....

Current Drivers Licence: Yes No Licence Number:

Any Current Restrictions:

Do you have any skills/knowledge/abilities that may not be directly related to this position, but may be useful in the future? (eg: second language, typing skills, computer literate etc....).

.....

.....

Please outline how you believe you would be suited to this position. (please address the requirements stated in the position description by making reference to your skills/knowledge/abilities – please use a separate sheet of paper if necessary.)

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Albury Wodonga Health is a Smoke-free workplace and Health Promoting Health Service.
We are an Equal Opportunity employer and do not tolerate/condone Workplace Bullying or Harassment.



Pre-Employment Health Declaration

Employment with Albury Wodonga Health is conditional on the applicant being a fit and proper person and fully able to perform the inherent requirements of the position. When completing the pre-employment health declaration it must be in full knowledge of the position as outlined in the position description and selection criteria. Read the documents carefully and discuss any queries that you may have prior to completing the form with the respective Manager or the Human Resource Manager.

The primary purpose of this pre-employment health declaration is to assist Albury Wodonga Health to ensure that no person is placed in an environment or given tasks that will result in physical or mental harm. It is not the intention of the pre-employment health declaration to deny a person employment solely because of disability or illness. The pre-employment health declaration does enable, where applicable, appropriate and reasonable action to be taken by Albury Wodonga Health to meet the provisions of Sections 82 (7) and (8) of the *Accident Compensation Act 1985* and Section 21 of the *Occupational Health and Safety Act 2004*.

Section 82 (7) and (8) of the Accident Compensation Act 1985 requires disclosure to your employer of any pre-existing injuries or disease that you have suffered, or existing injuries or disease that you continue to suffer from which you are aware and could reasonably be expected to foresee, and could be affected by the nature of the proposed employment referred to above.

Section 21 of the Occupational Health and Safety Act 2004 states that an employer shall provide and maintain, as far as is practicable, for employees a working environment that is safe and without risks.

Failure to make a disclosure, or the making of a false or misleading disclosure, may significantly limit, or remove, any entitlement you may have had to compensation pursuant to the Accident Compensation Act 1985 (WorkCover) should you suffer any recurrent, aggravation, exacerbation, acceleration or deterioration of a pre-existing injury or disease arising from employment with Albury Wodonga Health. Albury Wodonga Health may rely upon any failure to disclose in accordance with the provisions of the Accident Compensation Act as grounds for denying compensation.

Privacy

Albury Wodonga Health takes your privacy seriously. All details provided on this form are treated confidentially. The completed pre-employment health declaration form will be retained on your personnel file. Your personnel file is kept secure at all times. Where employment is not taken up, for whatever reason, all documents relating to your application will be retained for a period of two (2) years after the finalisation of any appointment process and then destroyed in accordance with Record Keeping Standards as required by the Public Records Office Victoria.

Your health declaration may be disclosed to an independent medical examiner should Albury Wodonga Health require an assessment of your suitability for employment and fitness for duty. Your health declaration may also be disclosed to Albury Wodonga Health's Work Cover Insurer (Agent) should you submit a Work Cover claim for compensation.

Should any circumstances change that may affect your capacity to perform the inherent requirements of the position that you are undertaking, you are obligated to inform your respective manager or the Human Resource Manager. You may have access to your personnel file. This may be undertaken by appointment with the Pay Office or the Human Resource Manager.

The following declaration is made for the purposes of Sections 82(7)-(9) of the Accident Compensation Act 1985:

I, (name of applicant) declare that:

I acknowledge that I am required to disclose all pre-existing injuries or diseases that I am aware of, and one could reasonably be expected to foresee could affect the nature of the proposed employment.

AND

I make responses to the following questions as follows:

<p>Q1: Are you aware of any circumstances regarding your health or capacity to work that would interfere with your ability to perform the duties of the position for which you are applying?</p> <p><i>In answering this question "Yes" or "No", you are also covering factors such as: existing or exposure to infectious diseases, taking of medications/treatment on a regular basis (daily, weekly, monthly).</i></p>
<p>NO <input type="checkbox"/> YES <input type="checkbox"/> If Yes, please provide details.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
<p>Q2. Do you have an existing injury or condition or pre-existing injury or condition?</p> <p><i>Existing is a condition for which treatment is still being received. Pre-existing is where an injury or condition(s) is/are present but treatment is not required. If Yes, please provide details of the injury or condition(s).</i></p>
<p>NO <input type="checkbox"/> YES <input type="checkbox"/> If Yes, please provide details.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
<p>Q3. Have you ever worked with any substances or in any conditions which may have been hazardous to your health (e.g.: asbestos exposure, toxic chemicals, stressful or noisy environments) and for which you needed a modified workplace?</p>
<p>NO <input type="checkbox"/> YES <input type="checkbox"/> If Yes, please provide details.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>

Where you have a pre-existing injury and/or disease, consideration will be given to reasonable modifications to the environment or tasks.

Do you agree to the following:

- | | | | | |
|--|-----|--------------------------|----|--------------------------|
| 1. To undergo a Medical fitness test? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 2. Albury Wodonga Health requesting a confidential report from nominated previous employers? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 3. Albury Wodonga Health requesting a confidential report from nominated current employer? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

Comments:

.....

You will be asked for details of nominated persons if reports are required.

Furthermore, if appointed, I agree:

- To abide by the By-Laws, Policies and Procedures of the Albury Wodonga Health Service as determined by the Department of Human Services and Board of Management.
- To respect the absolute confidentiality of all patients, clients and personnel and I realise that breaches by myself may result in disciplinary action or dismissal action being taken.

I acknowledge that any non-disclosure or false or misleading information on my part may result in Section 82(8) of the Accident Compensation Act 1985 being applied. This would limit or remove any entitlement by me or my dependants from receiving benefits relating to any recurrence, aggravation, exacerbation, acceleration or deterioration of any pre-existing injury or disease that I may have.

I do solemnly and sincerely declare that the contents of this form are true and correct in every particular, and make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of an Act of Parliament of Victoria rendering persons making a false declaration to be punishable for wilful and corrupt perjury.

The information stated is true and complete to the best of my knowledge and no information concerning my past or present state of health has been withheld. I hereby agree to undergo a health assessment by a medical practitioner if deemed necessary by Albury Wodonga Health.

I am aware that I may be required to undergo a hearing test. I will be advised that if a work related noise induced hearing deficit is detected that a compensation claim should be lodged against the relevant past employer. I am aware that the record of audiometry will be held in my file. I am aware that I will be asked to meet the cost of these examinations/reports.

I understand that any wilfully incorrect or misleading answer or material omission which relates to any of the questions before mentioned, may make me ineligible for employment, or if employed, liable to dismissal. I understand that this pre-employment health declaration will form part of my file.

SIGNATURE:

Date: ____/____/____



STAFF IMMUNISATION SURVEY

Albury Wodonga Health – Wodonga Campus assesses the vaccination status of staff to ensure that our Health Care Workers are offered appropriate vaccination to reduce their risk from vaccine preventable diseases.

Staff Immunisation Data is stored securely in accordance with Privacy Legislation. Immunisation data provides baseline information on staff immunisation status. This data may be used in the management of outbreaks or epidemics of vaccine preventable diseases. The Infection Control Department follows the Victorian Department of Human Services Immunisation Guidelines.

Please read and complete this form carefully. Please ensure you complete both pages and return to the Infection Control Department WITH documented evidence of previous vaccination or immunity as soon as possible.

NAME: _____ Date of Birth: 22 October 2009

HEPATITIS A

- Have you had Hepatitis A? YES NO
- Have you had Hepatitis A vaccine? YES NO
- Will you consent to receive Hepatitis A vaccine? YES NO

HEPATITIS B

- Have you had Hepatitis B? YES NO
- Have you had a full course of three Hepatitis B injections? YES NO
- Have you had a post-course blood test to assess your Hepatitis B antibody level? YES NO
- Did you have protective antibody levels? YES NO
- Will you consent to receive Hepatitis B vaccine? YES NO

MEASLES / MUMPS / RUBELLA

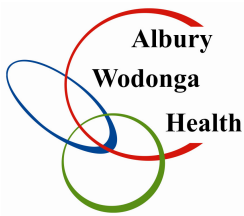
- Have you had Measles? YES NO
- Have you had Mumps? YES NO
- Have you had Rubella (German Measles)? YES NO
- Have you had MMR vaccine?
(Combined Measles / Mumps / Rubella vaccine) YES NO
- If born since 1966**, do you have documented evidence of at least two doses of a measles containing vaccine? YES NO
- Have you had blood tests to assess your Measles antibody level? YES NO
- Will you consent to receive MMR vaccine? YES NO

VARICELLA (CHICKEN POX)

- Have you had Varicella (Chicken Pox)? YES NO
- Have you had Varicella vaccine? YES NO
- Will you consent to receive Varicella vaccine? YES NO

DIPHTHERIA / TETANUS

- Have you had Diphtheria? YES NO
- Have you had Diphtheria / Tetanus vaccines?
(As a course of three Triple Antigen or ADT) YES NO
- Will you consent to receive Diphtheria/Tetanus vaccine? YES NO



STAFF IMMUNISATION SURVEY (CONTINUED)

PERTUSSIS (Whooping cough)

Have you had Pertussis vaccine? YES NO

Will you consent to receive Pertussis vaccine? YES NO

POLIOMYELITIS

Have you had Polio infection? YES NO

Have you had Polio vaccine? YES NO

Will you consent to receive Polio vaccine? YES NO

SMALL POX

Have you had Small Pox vaccination? YES NO

Will you consent to receive Small Pox vaccination? YES NO

INFLUENZA VACCINE

Do you wish to receive annual flu immunisation? YES NO

MANTOUX SKIN TEST / TUBERCULOSIS

Have you had Tuberculosis (TB)? YES NO

Comments: _____

Have you had a Mantoux Skin Test? YES NO

Year of last Mantoux Skin Test: Year: _____

Was your last Mantoux Skin Test stated to be: Positive

Negative

Strong Positive

If the test was positive what was the size of the reaction? _____ mm

Did you require a medical follow-up? YES NO

Did you have a Chest X/ray as a follow-up? YES NO

Were you referred to an Infectious Diseases Physician as follow-up? YES NO

Will you consent to receive BCG vaccination? YES NO

ALLERGIES

Do you have any allergies to drugs or food? YES NO

If yes, please list: _____

STATEMENT:

I acknowledge that any non-disclosure or false or misleading information on my part may result in Section 82(8) of the Accident Compensation Act 1985 being applied. This would limit or remove any entitlement by me or my dependants from receiving benefits relating to any recurrence, aggravation, exacerbation, acceleration or deterioration of any pre-existing injury or disease that I may have.

Signed:

Date: ____/____/____