HOLLY BLUE HEALTHCARE

Employment Application Form

Position Sought

Position Title:	
Department:	
Employment Status:	☐ Full time ☐ Part time ☐ Casual ☐ Temporary ☐ Permanent
How did you find out about this position?	☐ Holly Blue Website ☐ Internet ☐ Newspaper ☐ Word of Mouth ☐ Internal advertisement ☐ Other ________________

Personal Details

Title:	☐ *Mr* ☐ *Mrs* ☐ *Ms* ☐ *Miss* ☐ *Dr* ☐ *Other*		
Surname:			
Given Name:			
Preferred Name:			
Address:	**Suburb:** **Postcode:**		
Telephone (home):		**Telephone (mobile):**	
Email address:			

Eligibility to Work in Australia

Are you an Australian citizen?	☐ **Yes** ☐ **No**
If NO, have you been granted Permanent Residency?	☐ **Yes** ☐ **No**
If NO, have you been granted a temporary Visa / Working Permit?	**Yes** **No**
If YES, please provide Visa details: *These details are used to verify the currency and work eligibility under the visa and by completing this section you authorise the release of information from the Department of Immigration.*	**Type:** **Visa Number:** **Passport Number:** **Valid From:** **Valid To:**

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Health Assessment

Holly Blue Healthcare is an Equal Employment Opportunity employer, and therefore a medical condition, disability or previous Workers Compensation claim is not a barrier to the potential offer of employment.

Please provide details of any previous or current medical condition or restriction, physical or otherwise, which may affect your ability to perform the inherent and essential requirements of the role. Offers of employment are conditional upon you being assessed as being fit to safely undertake the duties of the proposed position without placing yourself or others at a risk of injury.

This must include any medical condition or restriction arising from a previous workers' compensation claim. Failure to provide such information may jeopardise your rights to workers' compensation if a pre-existing disability is aggravated at work (Section 79 of the Workers' Compensation and Rehabilitation Act 1981).

Please select from the following list any illnesses, injuries or disabilities which you have had, or are currently suffering:

Condition	Yes	No	Condition	Yes	No
High/Low blood pressure problems	☐ Yes	☐ No	Stress related condition	☐ Yes	☐ No
Visual problems	☐ Yes	☐ No	Whiplash	☐ Yes	☐ No
Difficulty hearing or with balance	☐ Yes	☐ No	Hernia or abdominal ulcers	☐ Yes	☐ No
Back /neck trouble or pain	☐ Yes	☐ No	Blood or body fluid borne disease	☐ Yes	☐ No
Injury of any kind	☐ Yes	☐ No	Heart trouble or experienced chest pain	☐ Yes	☐ No
Bone fractures or dislocations	☐ Yes	☐ No	Seizures/fits, fainting or dizzy spells	☐ Yes	☐ No
Hip/Knee trouble/pain/injuries	☐ Yes	☐ No	Psychological or psychiatric problems i.e. anxiety, depression, stress, panic attacks etc	☐ Yes	☐ No
Ankle trouble/pain	☐ Yes	☐ No	Discharged or resigned from a job due to medical reasons	☐ Yes	☐ No
Foot / toe trouble/ pain	☐ Yes	☐ No	RSI, Overuse Syndrome or Carpal Tunnel Syndrome	☐ Yes	☐ No
Skin rashes/problems, eczema, dermatitis	☐ Yes	☐ No	Shortness of breath, asthma, wheeze or suffer from breathing difficulties	☐ Yes	☐ No
Shoulder/elbow or wrist trouble/pain	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Hand/ finger trouble /pain	☐ Yes	☐ No	Immunosuppressed including receiving chemotherapy or long-term steroid use	☐ Yes	☐ No
Allergies or sinusitis	☐ Yes	☐ No	Drug or alcohol addiction	☐ Yes	☐ No
Health effects from contact with chemicals	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Exposure to noise in previous employment	☐ Yes	☐ No	Chronic joint injury including stiffness or pain	☐ Yes	☐ No
Tendency to bruise or bleed excessively	☐ Yes	☐ No	Rheumatics or arthritis of any kind	☐ Yes	☐ No
Persistent headaches	☐ Yes	☐ No	Muscle, tendon or ligament problem	☐ Yes	☐ No
Sporting, vehicle, work related illness or injury	Yes	No	Other:_______________________	Yes	No

If you selected any of the above, please provide details including treatment obtained and current state of injury or illness:

Are there any duties of the position you have applied for which you are, or may be, unable to do due to health problems or physical disability?

☐ **Yes** ☐ **No**

If yes, please give details:

Have you ever been a patient or worked in a hospital outside Western Australia or overseas in the last twelve months? If yes, please give details:

☐ **Yes** ☐ **No**

Are you known to have any condition likely to result in transmission of infection to others? If yes, please give details:

☐ **Yes** ☐ **No**

Have you ever claimed workers compensation? If yes, please give date and details:

☐ **Yes** ☐ **No**

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If yes, is the workers compensation claim still open? Are you still receiving treatment?:

Holly Blue Healthcare may contact you if further information is required. A medical examination may be required. Failure to attend an appointment for the medical examination may result in a contract of employment not being offered or being revoked.

Would you be willing to attend a medical examination if considered necessary? If no, please give reasons:

☐ **Yes**	☐ **No**

Diversity Questionnaire

Why do we need this information?
We need a diverse workforce in this organisation so that we can:

- meet the diverse needs of the community that we serve, and
- provide equal opportunity for all people in employment;
- assist with workforce planning
- Please answer all question. If you prefer not to say, please tick 'undisclosed'.

Confidentiality
Maintaining the confidentiality of your personal information is of utmost concern to us. This information will be held in confidence on our personnel system and will only be used for the purpose of developing equal employment opportunity and diversity policies, programs and reporting for the organisation.

1. Non-English-speaking background

☐ **Yes** ☐ **No** ☐ **Undisclosed**

☐ If yes, which language:

2. Aboriginal/Torres Strait Islander

☐ **Yes** ☐ **No** ☐ **Undisclosed**

3. Any disabilities

☐ **Yes** ☐ **No** ☐ **Undisclosed**

If yes, does your disability require adjustments in the workplace?

4. Gender

☐ Male ☐ Female ☐ Non-binary
☐ Prefer not to say

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Immunisation/Screening Form

It is a requirement of employment at Holly Blue Healthcare, that all employees who have a risk of exposure to bodily fluids or infectious agents in the workplace including clinical staff, carers or support workers have a pre-employment assessment to ensure that it is current and appropriate for their category of employment.

Please complete below**.** All details must be completed and returned with your application to enable an informed decision to be made when reviewing your status and making any recommendations. In addition, please provide **proof of evidence of immunity,** if you have these documents. All costs associated with visit/s to a GP will be the responsibility of the applicant.

1. Methicillin Resistant Staphylococcus Aureus (MRSA)	
Have you worked or volunteered in or been a patient in a hospital outside WA during the last 12 months?	☐ **Yes** ☐ **No**
Have you worked or volunteered in a Residential Aged Care Facility outside WA during the last 12 months?	☐ **Yes** ☐ **No**
If yes, a visit to a GP is required, as screening is a mandatory pre-commencement into Residential or Community Aged Care in accordance with a W.A. Department of Health directive	

2. Tuberculosis Risk Assessment	
a. Have you ever had a BCG (Vaccination against TB)? When? ________________________________	☐ **Yes** ☐ **No**
b. Have you had contact, personally or at work with somebody that has had TB?	☐ **Yes** ☐ **No**
c. Have you had a Mantoux skin test (please provide results)? When? ________________________________	☐ **Yes** ☐ **No**
d. Do you have a history of immune deficiency?	☐ **Yes** ☐ **No**
If yes to question b or d a visit to a GP is required, as screening is a mandatory pre-commencement in accordance with a W.A. Department of Health directive	

3. Have you had the following immunisation:	
Diphtheria	☐ **Yes** ☐ **No** ☐ **Unsure**
Tetanus	☐ **Yes** ☐ **No** ☐ **Unsure**
Polio	☐ **Yes** ☐ **No** ☐ **Unsure**
Mumps (please provide proof of immunity)	☐ **Yes** ☐ **No** ☐ **Unsure**
Varicella (Chicken Pox) (please provide proof of immunity)	☐ **Yes** ☐ **No** ☐ **Unsure**
Rubella (German Measles) (please provide proof of immunity)	☐ **Yes** ☐ **No** ☐ **Unsure**
Measles (please provide proof of immunity)	☐ **Yes** ☐ **No** ☐ **Unsure**
If born after 1966 have you received a measles booster?	☐ **Yes** ☐ **No** ☐ **Unsure**
Meningococcal	☐ **Yes** ☐ **No** ☐ **Unsure**
Adult Pertussis (Whooping Cough) booster?	☐ **Yes** ☐ **No** ☐ **Unsure**
Hepatitis B (the full course of 3 injections)	☐ **Yes** ☐ **No** ☐ **Unsure**

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APPLICATION DECLARATION

I declare the above information to be true in all aspects.

I acknowledge that any statement which I have made which is found to be false or deliberately misleading will make me, if employed, liable for dismissal.

I understand that part of the application procedure may involve a medical examination by a medical officer nominated by Holly Blue Healthcare, and I authorise disclosure of the results of this examination to Holly Blue Healthcare.

Name:			
Signed:		**Date:**	

Please attach the following as part of your application: ***(note: failure to provide complete documentation will result in a delay in progressing your application)***	**General Applicants:** ☐ Proof of Citizenship (e.g. copy of passport OR Australian birth certificate) ☐ Copy of WWC Card (where applicable) ☐ Original copy of National Police Clearance (no older than 6 mths) ☐ Copy of your current resume ☐ Copy of relevant qualifications (as requested) ☐ Copy of vehicle registration ☐ Copy of vehicle insurance **Nursing/Allied Health and others as requested** ☐ Copy of qualifications ☐ Copy of AHPRA registration (nursing, allied health)

Privacy: Your application form contains personal information, which will be dealt with in accordance with our Privacy Policy. If you are successful in your application your form will become an employment record. If you are unsuccessful your application form will be destroyed.

PLEASE SAVE THE COMPLETED FORM AND EMAIL TO: enquiries@hollyblue.com.au

OFFICE USE ONLY

☐ **Application details verified and confirmed as complete**

☐ **Acknowledgement letter sent (date):** Date:

☐ **Interview date/time:**

☐ **Outcome:** ☐ **Applicant notified (date):**