

Application for Employment



The Application for Employment form is required to be submitted with the following documents:

- Covering letter in support of application
- Response to selection criteria
- Applicants curriculum vitae

POSITION APPLIED FOR	
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PERSONAL DETAILS			
Surname		Given name	
Address		Home phone	
		Mobile	
		Email address	
Are you an Australian Citizen			Yes <input type="checkbox"/> No <input type="checkbox"/>
If no, do you have permanent Australian Residency Status			Yes <input type="checkbox"/> No <input type="checkbox"/>

EDUCATION, PROFESSIONAL, TRADE QUALIFICATIONS, ASSOCIATIONS		
Qualification / Membership	Date Obtained / Current	Institution / Association

PRACTICING CERTIFICATES AND REGISTRATIONS (DETAIL NURSES BOARD, ALLIED HEALTH, TRADE, OTHER)			
Board / Registering Body		Reg. No	
Registration Type		Expiry Date	
Board / Registering Body		Reg. No	
Registration Type		Expiry Date	
Board / Registering Body		Reg. No	
Registration Type		Expiry Date	

PRESENT EMPLOYMENT	
Employer	
Position held	
Starting date	
Main responsibilities	

PAST EMPLOYMENT (PLEASE LIST IN ORDER THE TWO MOST RECENT POSITIONS HELD. FURTHER INFORMATION MAY BE SUPPLIED IN YOUR CV)			
Job Title		Job Title	
Employer		Employer	
Type of Business		Type of Business	
Period of Employment		Period of Employment	
Reason for Leaving		Reason for Leaving	

REFEREES (PLEASE DETAIL TWO REFEREES, PREFERABLY CURRENT EMPLOYERS)			
Name		Name	
Position / Title		Position / Title	
Organisation		Organisation	
Relationship		Relationship	
Email		Email	
Mobile		Mobile	
Work Phone		Work Phone	

PREVIOUS EMPLOYMENT SPECIFICS	
Are you a former Victorian Public Sector Employee who has received a voluntary departure package?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please provide details	
Are you currently on any form of paid or unpaid leave from any other employer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please provide details	

HEALTH AND SAFETY REQUIREMENTS (DECLARATION OF A MEDICAL OR HEALTH CONDITION DOES NOT EXCLUDE YOU FROM EMPLOYMENT WITH INDIGO NORTH HEALTH INC.)	
Are you aware of any medical or health related condition that could affect your performance or abilities to carry out the requirements of the role you are applying for, or be exacerbated by the work you will be doing?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please specify	
Have you ever lodged a claim for an occupational or work related injury or illness?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please specify	
Are you currently on leave due to a WorkCover incident?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If you are currently suffering, or have suffered from a past injury or illness, are there any arrangements and modifications Indigo North Health Inc. could provide to enable you to carry out the role requirements safely and effectively?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please specify	

STATEMENT OF CONFIRMATION	
<p>I confirm that the information given on this form is true and complete. I acknowledge that any false or misleading information may be sufficient cause for rejection of this application, or if employed, dismissal of employment.</p> <p>I acknowledge that failure to disclose a medical or health condition may compromise my entitlements to WorkCover benefits in the event of a recurrence, aggravation, exacerbation or deterioration of a pre-existing injury or disease arising out of, or due to employment with Indigo North Health Inc.</p> <p>I consent to Indigo North Health Inc seeking verbal or written information about me from referees detailed within this application.</p> <p>I understand that the information provided within this application will be treated confidentially, and will only be used in relation to the application for employment of the stated role.</p>	
Signature	Date