

Interest Of Employment Form

Title Mr Mrs Ms Miss (please tick)

Surname _____ First Name _____

Occupation _____ DOB: _____

Residential Address _____ Post Code _____

Home Phone No. _____ Mobile No. _____

Email: _____

Next of Kin _____ Emergency Name _____

Phone No _____

Drivers License Yes No (please tick) Licence No. _____
Class _____

Any Other Licenses or Trade Tickets

Any Tertiary Certificates

Medical
A full medical check up is required for all employees of the company and a Medical Certificate obtained for our records.

Have you ever made any workers compensation claims in the last five years? Yes/No

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Sunchip Group Management System

Interest Of Employment Form

Current Employment:

Employer:..... Commenced:.../.../....

Position/s:.....

Major Duties:.....

.....

.....

Employment History – Previous Ten Years 9in including Vacation/Part-time Work/ Work Experience)

Employer (Most Recent First)	Position	From – To	Reason For leaving

Professional Referees: (People you have worked with or for excluding relatives)

Name	Position/Title	Company	Phone

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MEDICAL DETAILS

NAME:			
HAVE YOU NOW, OR IN THE PAST HAD ANY OF THE FOLLOWING?	NO	YES	IF "YES", PLEASE GIVE DETAILS
AN INJURY, ILLNESS OR OPERATION			
DIABETES			
EPILEPSY			
HIGH BLOOD PRESSURE			
RHEUMATIC FEVER			
ASTHMA			
FRACTURE OR SPRAINS TO LIMBS			
BACK PAIN, BACK COMPLAINTS			
FAINTING OR FITS			
ALLERGIES			
JOINT TROUBLE			
HERNIA OR RUPTURE			
MUSCULAR PROBLEMS			
MENTAL, NERVOUS DISORDER			
SKIN DISEASES, DERMATITIS			
STOMACH, DUODENAL ULCER			
CANCER GROWTH, TUMOR			
EAR DISEASE, SINUS TROUBLE			
NECK PROBLEMS			
CHEST COMPLAINTS			
FOOT OF LEG COMPLAINTS			
REPETITIVE STRAIN INJURIES			
PERMANENT DISABILITY FROM BIRTH, OR DUE TO INJURY OR DISEASE			
INFECTIOUS DISEASES – ie Measles, Mumps, Chicken Pox, Glandular Fever, Hepatitis A/B/C, TB			
ANY OTHER CONDITION NOT LISTED ABOVE?			
EXPOSURE TO EXCESSIVE NOISE			
EXPOSURE TO ASBESTOS OR CERAMIC FIBRES			
EXPOSURE TO REPETITIVE TASKS			
DO YOU WEAR SPECTACLES OR CONTACT LENS?			
ARE YOU CURRENTLY HAVING ANY MEDICAL TREATMENT			

DO YOU SMOKE? (Please tick one)	YES HAVE NEVER SMOKED HAVE GIVEN UP	FOR HOW MANY YEARS?	HOW MANY PER DAY?	DO YOU DRINK ALCOHOL? (Please tick one)	DAILY WEEKLY OCCASIONALLY NEVER
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HAVE YOU EVER MADE ANY WORKERS COMPENSATION CLAIMS? YES / NO		IF "YES", PLEASE GIVE DETAILS
YEAR	INJURY	NAME OF EMPLOYER

I hereby certify that the above particulars are correct to the best of my knowledge. I understand that any inaccurate statement made by me, or information withheld by me, may result in any Workers Compensation benefits being reduced, and may result in my employment being terminated.

SIGNED..... DATE.....

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I, _____ declare

- a) That the answers to the foregoing are to the best of my knowledge true and correct in every particular.
- b) That if my application for employment is successful, I will be bound by and at all times observe and respect such terms and conditions relating to the contract of employment, and at all times will obey such policies and rules as from time to time instructed, specified or otherwise stipulated by the employer and its officers.
- c) That I understand that any false declaration made by me in this application subjects me to dismissal without notice.
- d) That I understand and agree that through participating in the selection process the employer may require me to undergo a medical assessment at my own expense and if so engaged, agree to continue to participate in such programs from time to time as required by the employer, at the employer's expense.
- e) After entering into a contract of employment with the employer I agree to submit to search by an officer of the employer of my person, or any vehicle, parcel or receptacle in my possession whilst performing day to day duties or on the employer's property.
- f) I agree to my pervious employers being requested to furnish a confidential report of my service, and any information that will assist in determination of my suitability for employment.
- g) I understand that if my application for employment is successful I will be bound by and at all times observe the relevant provisions of the Queensland Workplace Health and Safety Act and regulations pursuant thereto. I further agree to comply with any other safety requirements advised to me, either in writing or verbally, by an authorized officer of the employer.
- h) I understand that if my application for employment is successful I will be bound by at all times observed the relevant provisions of the employers Award, or Industrial Agreements, and relations pursuant thereto. I further agree to wherever possible and reasonable, accept responsibility for all personal protective equipment, equipment and uniforms supplied to me, equipment used by me, and keep same in good order and condition solely for the use in the course of my employment.

Signed _____ Date ____/____/____

PRINT NAME _____

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Attach any photocopies of any additional information (e.g. references, qualifications, skills) which support your application.

Also a traffic history report is required for the past 5 years and a copy of a current drivers licence

Return application form to:
Sunchip Group Pty Ltd

Fax: 07 4125 6774 or

info@sunchipgroup.com.au

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Sunchip Group- Driver Declaration

Section One – Driver to Complete

Please answer all questions below to the best of your knowledge. If there is insufficient room in any section please use the reverse side of this page and note the question being answered.

(1) Personal Details

Name _____

Address _____

_____ Postcode _____

Date of Birth ____/____/____

(2) Medical History

When was your last medical check up? _____

Did the medical check detail any concerns for:

Sleeping Disorders? Yes No Not Tested

Drug Use? Yes No Not Tested

Back Problems? Yes No Not Tested

Any other medical condition which may affect your ability to drive Yes No

If yes please provide details _____

I have a copy of my licence history which:

- Is from the relevant state government body
- Is no more than 30 days Old
- Provides details of at least the past five years

(3) Licence Details & Convictions

Licence No. _____

Expiry Date ____/____/____ State Issued _____

Class of Licence _____

Years Held this Class _____

If held for less than two years please note:

Previous Class _____ Years Held _____

Have you held a licence from another state or under another name in the past 5 years? Yes No

If yes please supply details _____

Are you currently employed as a Professional Truck Driver? Yes No

If no please advise the date you were last employed as a Professional Truck Driver _____

Have you had any Criminal Convictions in the past 5 years? Yes No

Has your licence been cancelled, suspended or endorsed in the past 5 years? Yes No

Have you been convicted of fined in the past 5 years for:

Alcohol Yes No

Dangerous Driving Yes No

Drug Offences Yes No

Culpable Driving Yes No

Negligent Driving Yes No

If Yes please provide details _____

(4) Please list any Motor Vehicle Accidents or claims where you were the Driver within the past 5 years

Date	Description	Approx \$ Value
		\$
		\$
		\$

(5) Please supply details of your past four employers (within the last 5 yrs) where driving was your position.

Company Details			Employment Period		Tasks and Freight	
Name	Contact	Phone No.	Start	Finish	Vehicle Class	Freight Carried

Signed: _____ Date: _____