Application Form

Applicant's Name:			
Address:			
Phone:		**Email:**	
DOB: / /		**Sex: Male / Female (please circle)**	
Position applying for:			

	Yes	No	Comments
Are you an Australian citizen or permanent resident? If no, please specify which visa you possess:			
Have you had any criminal convictions? Are you willing to undergo a criminal history check with Intelife?			If yes, details:
Do you have a current WA driver's licence?			Licence number:
Have you been fined or convicted of a speeding/other traffic offence (excluding parking) within the last 5 years? Have you had any serious traffic/driving offences within the last 5 years? Have you ever had insurance declined, cancelled, renewal refused or special conditions imposed? Have you had a driving licence endorsed, suspended or cancelled?			Provide details:
Do you give Intelife permission to check your driver's licence ongoing validity and demerit point/driving record?			

Availability:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning 8:00-12:00							
Afternoon 12:00- 18:00							

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Are they any limitations to your availability?	
If successful in this application/interview when would you be able to start?	
Have you attached? ☐ Statement addressing the selection criteria (if and as instructed within Job Pack) ☐ Cover letter ☐ Resume ☐ Application form	
All application must be submitted to: jobs@intelife.org	

PRE-EMPLOYMENT HEALTH QUESTIONNAIRE

As part of Intelife's selection process, it is necessary for potential candidates to complete a confidential pre-employment health questionnaire. This is part of the process to confirm that you are suitable to perform the inherent duties of the position for which you have applied, and to help prevent work-related illness and injury occurring subsequent to your employment.

EMERGENCY CONTACT					
Name:					
Relationship:					
Phone (H):		Phone(W):		Mobile:	
Family Doctor:				Phone:	

PERSONAL HEALTH

Do you smoke? Yes No If yes, how many per day? _____

Have you stopped smoking? Yes No If yes, when? _____

Do you drink alcohol? Yes No Average number of days per week _____

Number of drinks per sitting .....

Do you exercise? ..... Yes No If yes, what type? _____

Average number of days per week .....

Length of time each session.....

Have you any illness or disability at present?.....Yes No Specify: _____

Have you been involved in a Motor Vehicle Accident? .....Yes No Date:_____

Are you taking medicines, mixtures or tablets at present?..Yes No

If yes, please specify?_____

Have you ever had any allergy from, or reacted to any antibiotic, medicines, drugs, insect bites, food or anything else?
.....Yes No

If yes, please give details _____

_____

_____

Are you receiving treatment for any medical conditions? ...Yes No

If yes, please give details _____

_____

PERSONAL HEALTH HISTORY

Tick √ Yes or No to the following questions

1.	Do you have any physical disability?	☐ Yes	☐ No
2.	Is there any defect in the sight of either eye?	☐ Yes	☐ No
3.	Are you colour blind?	☐ Yes	☐ No
4.	Have you any defect in hearing?	☐ Yes	☐ No
5.	Are you affected by vertigo (fear of heights)?	☐ Yes	☐ No
6.	Are you able to work while located at a height?	☐ Yes	☐ No
7.	Do you suffer from claustrophobia (fear of confined spaces)?	☐ Yes	☐ No
8.	Have you had any heart trouble or angina?	☐ Yes	☐ No
9.	Have you ever had any nervous trouble, epilepsy or fainting?	☐ Yes	☐ No
10.	Have you suffered from depression or anxiety?	☐ Yes	☐ No
11.	Have you ever had skin trouble (dermatitis)?	☐ Yes	☐ No
12.	Do you have any allergies?	☐ Yes	☐ No
13.	Is there any family history of disease like diabetes?	☐ Yes	☐ No
14.	Have you a tendency to bleed or bruise excessively?	☐ Yes	☐ No
15.	Have you ever had Asthma, Tuberculosis or Pleurisy?	☐ Yes	☐ No
16.	Have you ever had Rheumatics or Arthritis of any form?	☐ Yes	☐ No
17.	Have you ever had Goitre or Thyroid troubles?	☐ Yes	☐ No
18.	Have you ever had high blood pressure?	☐ Yes	☐ No
19.	Have you ever had kidney or bladder disease?	☐ Yes	☐ No
20.	Have you ever had cancer or tumour of any kind?	☐ Yes	☐ No
21.	Have you ever had ear discharge, antrum or sinus trouble?	☐ Yes	☐ No
22.	Have you ever had persistent headaches?	☐ Yes	☐ No
23.	Have you ever had stomach ulcers, gall or kidney disorders	☐ Yes	☐ No
24.	Have you had any back/neck trouble of any kind?	☐ Yes	☐ No
25.	Have you had any severe injury or operation?	☐ Yes	☐ No
26.	Have you ever had any bone fractures or dislocations?	☐ Yes	☐ No
27.	Have you ever had any ankle/knee trouble of any kind?	☐ Yes	☐ No
28.	Have you ever had a rupture (hernia)?	☐ Yes	☐ No
29.	Have you ever had wrist/elbow trouble of any kind?	☐ Yes	☐ No
30.	Have you ever had repetitive strain injury?	☐ Yes	☐ No
31.	Have you ever had whiplash from an accident?	☐ Yes	☐ No

If **yes** has been selected for any items from 1-31, please complete below questions.

Please address all selected injuries/conditions in the below questions.

Date of the injury/condition: _____

Specification of the injury/condition? _____

_____

Restrictions from the injury/condition during Return to Work? (if applicable) _____

_____

Total days taken to recover from injury/condition? _____

_____

Is the Workers Compensation closed? (if applicable) _____

_____

Do you have any permanent restrictions? _____

_____

Has a "final" Certificate from the doctor "been issued? _____

_____

Do you have any ongoing pain or restrictions? _____

_____

PERSONAL HEALTH HISTORY CONTINUED

Have you ever had any illness or suffered any breakdown, met with any injury or wound or undergone any surgical operation not already stated above? ..... ☐ Yes ☐ No

If Yes, give details_____

_____

Have you ever had a workers' compensation claim? ..... ☐ Yes ☐ No

If Yes, how many and please give details_____

_____

Have you been involved in a Motor Vehicle Accident? ..... ☐ Yes ☐ No

If Yes, give details_____

_____

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MANUAL HANDLING

Have you ever been treated for an injury as a result of attempting to lift, lower, push, pull, carry or otherwise move, hold or restrain any object? ☐ Yes ☐ No

Do you suffer from any medical or health related condition that may affect your ability to lift, lower, push, pull, carry or otherwise move, hold or restrain any object? ☐ Yes ☐ No

Do you suffer from any medical or health related condition that may be affected by physical or strenuous work? (*Eg* repetitive strain injuries related to manual handling, lower back pain, hernia or haemorrhoids, a heart condition, high blood pressure, a respiratory condition such as asthma *etc*) ☐ Yes ☐ No

Have you had or do you currently have any of the following:

Swollen or painful joints ☐ Yes ☐ No

RSI ☐ Yes ☐ No

Knee injury ☐ Yes ☐ No

Fractures ☐ Yes ☐ No

Ankle injury ☐ Yes ☐ No

Neck injury ☐ Yes ☐ No

Back injury ☐ Yes ☐ No

Other joint injury ☐ Yes ☐ No

Shoulder injury ☐ Yes ☐ No

If you have answered 'yes' to any of the questions in this section, please provide details (*eg* dates, what happened, nature of injury/medical condition, treatment details, length of time off work, *etc*)

_____

_____

DRIVING

Are you currently being treated by a doctor for any illness or injury? ☐ Yes ☐ No

Are you receiving any medical treatment or taking any medication ☐ Yes ☐ No
(either prescribed or otherwise) Please take any medications with you to show the doctor.

Have you ever had or been told by a doctor that you had any of the following?

High blood pressure ☐ Yes ☐ No

Heart disease ☐ Yes ☐ No

Chest pain, angina ☐ Yes ☐ No

Any condition requiring heart surgery ☐ Yes ☐ No

Palpitations/irregular heartbeat ☐ Yes ☐ No

Abnormal shortness of breath ☐ Yes ☐ No

Head injury, spinal injury ☐ Yes ☐ No

Seizures, fits, convulsions, epilepsy ☐ Yes ☐ No

Blackouts, fainting ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Dizziness, vertigo, problems with balance ☐ Yes ☐ No

Double vision, difficulty seeing ☐ Yes ☐ No

Colour blindness ☐ Yes ☐ No

Kidney disease ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Neck, back or limb disorders ☐ Yes ☐ No

Hearing loss or deafness or had an ear operation or use a hearing aid ☐ Yes ☐ No

Do you have difficulty hearing people on the telephone (including use of hearing aid if worn) ☐ Yes ☐ No

Have you ever had or been told by a doctor that you had a psychiatric illness, or nervous disorder ☐ Yes ☐ No

Have you ever had any other serious injury, illness, operation or been in hospital for any reason ☐ Yes ☐ No

Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea or narcolepsy? ☐ Yes ☐ No

Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep? ☐ Yes ☐ No

DRIVING CONTINUED

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you?

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze off
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important you put a number (0 to 3) in each of the 8 boxes.

Situation	Chance of dozing (0 – 3)
Sitting and reading	☐
Watching TV	☐
Sitting, inactive in a public place (e.g. a theatre or meeting)	☐
As a passenger in a car for an hour without a break	☐
Lying down to rest in the afternoon when circumstances permit	☐
Sitting and talking to someone	☐
Sitting quietly after a lunch without alcohol	☐
In a car, while stopped for a few minutes in the traffic	☐

CHEMICAL EXPOSURE

Have you ever been treated for an injury, illness or side effect as the result of being exposed to chemical or toxic substances or using of PPE? (*eg* gloves) ..... ☐ Yes ☐ No

Do you suffer from any medical or health related condition that may be affected as the result of being exposed to medications, detergents, cleaning solutions, and pesticides? (*eg* respiratory conditions such as asthma, dermatitis or eczema, allergenic reactions, *etc*)..... ☐ Yes ☐ No

Is there any reason that you can't wear safety or protective equipment (*ie* safety foots, ear muffs or plugs, helmet or safety glasses)? ..... ☐ Yes ☐ No

Have you had or do you suffer from:

Eczema ..... ☐ Yes ☐ No

Dermatitis..... ☐ Yes ☐ No

Other skin problems..... ☐ Yes ☐ No

Allergies..... ☐ Yes ☐ No

Loss of consciousness ..... ☐ Yes ☐ No

Epilepsy or fainting..... ☐ Yes ☐ No

CHEMICAL EXPOSURE CONTINUED

If you have answered 'yes' to any of the questions in this section please provide details (*eg* dates, what happened, nature of injury/medical condition, treatment details, time off work, *etc*)

_____

_____

_____

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PSYCHOLOGICAL

Have you ever received medical treatment for a stress related condition? (*eg* ulcers, nervous trouble, insomnia, depression, anxiety or panic attacks, nervous breakdown) ..... ☐ Yes ☐ No

Have you ever received counselling for a stress related condition? ..... ☐ Yes ☐ No

Have you or do you suffer from a psychological condition? ..... ☐ Yes ☐ No

If you have answered 'yes' to any of the questions in this section please provide details (*eg* dates, what happened, nature of condition, treatment details, time off work, *etc*)

_____

_____

_____

INFECTIOUS DISEASES

Have you had any of the following diseases?

Measles ..... ☐ Yes ☐ No

Hepatitis ..... ☐ Yes ☐ No

German Measles ..... ☐ Yes ☐ No

Tuberculosis ..... ☐ Yes ☐ No

Chicken Pox ..... ☐ Yes ☐ No

IMMUNISATIONS

Have you been immunised against:

Tuberculosis ..... ☐ Yes ☐ No Year _____

Mantoux ..... ☐ Yes ☐ No Year _____

Hepatitis A ..... ☐ Yes ☐ No Year _____

Hepatitis B ..... ☐ Yes ☐ No Year _____

Rubella ..... ☐ Yes ☐ No Year _____

Other:

APPLICANTS DECLARATION

Do you have any other health concerns or medical conditions you are aware of that may affect

Your ability to undertake the work, or that

This organisation should be made aware of, so that it can fulfil its own duty of care to its employees.

If so, please provide details *(eg* dates, what happened, nature of injury/condition, treatment details, *etc*)

_____

_____

_____

_____

Section 79 of the Western Australian *Workers' Compensation and Injury Management Act 1981* gives a dispute resolution body discretion to refuse to award compensation which would otherwise be payable where it is proved that the worker has, at the time of seeking or entering employment in respect of which he claims compensation for an injury, wilfully and falsely represented themselves as not having previously suffered from the injury.

I, _____, hereby declare that the particulars on this form are, to the best of my knowledge, correct and true.

I also understand and am aware that any inaccurate statement made, or information withheld, may result in the termination of my employment/contract.

Signed: _____ Date: __ /_ /__

Print Name: _____

Witness

Signed: _____ Date: __ /__ /__

Print Name: _____