Application for Employment

1. Pre-Employment Information
2. General Medical Questionnaire
3. Declaration

Pre-Employment Information

(Applicant)

Position					
Tenure	Full time ☐	Part time ☐	Fixed Term ☐	Casual ☐	Casual Sales ☐
Anticipated State Date					

The personal information obtained in this form is confidential and is managed by [Company] in accordance with the *Privacy Act* 1988. The form will be placed on file with access restricted to nominated staff. Information contained in this form is not made available to any other third party without your written consent unless [Company] is required to do so by a court or tribunal or under law.

First Name		**Preferred Name**	
Surname			
Home Address (Must be provided)			
Mailing Address			
Home Phone		**Mobile Phone**	
Email Address			
Australian Citizen	Yes ☐ No ☐ If no, please provide visa details below.		
Visa Details Original Passport will be required to be sighted for verification with Department of Immigration & Citizenship	**Family Name (as in Passport)**		
	Given Names (as in Passport)		
	Passport Number		
	Nationality of Passport		
	Date of Issue		
	Date of Birth		
	Visa No. & Type		
	Expiry		

Pre-Employment Information

(Applicant)

Qualifications and Certifications

Racing NSW	Have you ever been refused registration by a racing authority (eg. Racing Victoria, Racing NSW, etc.) or any other racing authority? Yes ☐ No ☐ Do you currently hold a Stable Hand registration? Yes ☐ No ☐ Issuing state: _____ Are you currently a licensed Jockey / Trainer? Yes ☐ No ☐ Yes / No Have you completed the mandatory training required by the Principal Racing Authority? Yes ☐ No ☐
Other Tickets	
Tertiary Education If none provide last school attended and level completed	
First Aid or St Johns Ambulance Certification Provide details and dates including expiry	

Driver Licence

Should employment be offered, your Driver Licence will be required for copying and verification before you can drive a [Company] vehicle.

Do you have a current Driver Licence?	Yes ☐ No ☐ If no, state why (include any suspensions):			
Years Driving Experience				
Licence class	Car ☐	Rider ☐	Light Rigid ☐	Medium Rigid ☐

	Heavy Rigid ☐	Heavy Combination ☐	Multi Combination ☐
Expiry date			
Any special conditions or restrictions?	☐ P1	☐ P2	Mandatory Alcohol Interlock Program ☐
	Other		

Smoking

Please note that [Company] is a non-smoking working environment in all buildings, workshops and adjacent external areas.

Pre-Employment Information

(Applicant)

Previous Employment

If resume provides all details required below please tick and move to page 4 ☐

Present/Last Employer			
Start Date		End Date	
Position Held			
Duties			
Reason for Leaving			
Name and phone number of Referee			

Previous Employer			
Start Date		End Date	
Position Held			
Duties			
Reason for Leaving			
Name and phone number of Referee			

Previous Employer			
Start Date		End Date	
Position Held			
Duties			
Reason for Leaving			
Name and phone number of Referee			

Pre-Employment Information

(Applicant)

Additional Referees

Please provide details of additional referees other than relatives and close friends. Preferably previous employers.

Referee 1:	Name	
	Relationship	
	Phone	

Referee 2:	Name	
	Relationship	
	Phone	

Referee 3:	Name	
	Relationship	
	Phone	

Please provide any other information that may assist in your application for employment with [Company].

Literacy

Is English your first language?	Yes ☐	No ☐ If no, please state _____
What is your level of English literacy and numeracy?	Primary School ☐	Record of School Achievement (RoSa) or Year 10 Certificate ☐
	Higher School Certificate ☐	Tertiary ☐

General Medical Questionnaire

(Applicant)

Have you previous had any work related injuries?

If yes, please complete the following:

Date	Type of Injury	Treatment

Did you bring a workers compensation claim in respect to the injury(s) above?

If yes, please provide details of the claim including the employer, insurance company and claim number.

Employer	
Insurer	
Claim Number	
Type of Injury	
Date of injury	
Treatment	

Employer	
Insurer	
Claim Number	
Type of Injury	
Date of Injury	
Treatment	

Have you previously been in any motor vehicle accident?

If yes, please provide: (if you require more space please use a separate page)

Date	Injury(s)	If claimed, claim number

General Medical Questionnaire

(Applicant)

Have you had any other accidents or illnesses that may impact on upon you performing your duties?

If yes, please give details:

_____

_____

_____

_____

Tetanus Immunisation Date _____ Blood Group _____

Allergies if yes list: 1. 2. 3.

4. 5. 6.

Family History

Have any of your immediate family (father, mother, brothers, sisters, sons or daughters) dead or alive suffered from: (Please ✓ the appropriate box)

	Yes	No		Yes	No		Yes	No
Asthma	☐	☐	Heat Disease	☐	☐	Mental Illness	☐	☐
Hay fever	☐	☐	High Blood Pressure	☐	☐	Cancer	☐	☐
Skin Disease	☐	☐	Diabetes	☐	☐			

Personal History

Have you suffered from any of the following? (Please ✓ the appropriate box)

BLOOD	Yes	No	HEART	Yes	No	KIDNEY/LIVER	Yes	No
High blood pressure	☐	☐	Rheumatic Fever	☐	☐	Hepatitis	☐	☐
Low blood pressure	☐	☐	Palpitations	☐	☐	Jaundice	☐	☐
Anaemia	☐	☐	Murmurs	☐	☐	Kidney Disease	☐	☐
any other blood disease	☐	☐	Angina	☐	☐	Blood in urine	☐	☐

General Medical Questionnaire

(Applicant)

EYES	Y	N
Blurred vision	☐	☐
Loss of vision	☐	☐
Cataracts	☐	☐
Glasses	☐	☐
Contacts	☐	☐

STOMACH	Y	N
Frequent Indigestion	☐	☐
Heartburn	☐	☐
Duodenal Ulcer	☐	☐
Stomach Ulcer	☐	☐
Passing blood in bowels	☐	☐
Persistent Diarrhoea	☐	☐

EARS	Y	N
Persistent Earache	☐	☐
Discharge from ears	☐	☐
Deafness	☐	☐
Industrial Deafness	☐	☐
Sinusitis	☐	☐
Tinnitus	☐	☐
Hearing aids	☐	☐

CHEST	Y	N
Shortness of breath	☐	☐
Persistent cough	☐	☐
Palpitations	☐	☐
Chest pains	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Pneumonia	☐	☐
Pleurisy	☐	☐
Tuberculosis	☐	☐
Hay fever	☐	☐
Cough up blood	☐	☐

HEAD & NERVES	Y	N
Fainting attacks	☐	☐
Frequent blackouts	☐	☐
Severe headaches	☐	☐
Migraines	☐	☐
Giddiness	☐	☐
Epilepsy/fits	☐	☐
Previous concussion	☐	☐
Previous head injury	☐	☐
Anxiety	☐	☐
Depression	☐	☐

NECK / BACK	Y	N
Previous back injury	☐	☐
Pain in neck & shoulders	☐	☐
Previous neck injury	☐	☐
Lumbar pain	☐	☐
Sciatica i.e. pain radiating down legs	☐	☐
Slipped or prolapsed disc	☐	☐
Fracture of cervical spine	☐	☐
Persistent back ache	☐	☐
Cartilage trouble	☐	☐
Fracture of Lumbar or Thoracic Spine	☐	☐

General Medical Questionnaire

(Applicant)

LEGS	Y	N		Y	N	ARMS / HANDS	Y	N
Previous injuries to knee	☐	☐	Ankle injuries	☐	☐	Previous arm injuries	☐	☐
Any arthroscopies	☐	☐	Foot Trouble	☐	☐	Rotator cuff injury	☐	☐
Knee surgery	☐	☐	Arthritis	☐	☐	RSI	☐	☐
Knee replacement	☐	☐	Are you required to wear special shoes	☐	☐	Dislocation of wrists	☐	☐
Broken/fractured bones	☐	☐				Broken/fractured bones	☐	☐
Achilles damage	☐	☐				Arthritis	☐	☐

SKIN	Y	N	PHOBIAS	Y	N
Eczema	☐	☐	Heights	☐	☐
Dermatitis	☐	☐	Crowds	☐	☐
Other Skin Condition	☐	☐	Confined spaces	☐	☐

GENERAL INFORMATION

	Y	N		Y	N		Y	N
Travel sickness	☐	☐	Cancer	☐	☐	Rheumatic Fever	☐	☐
Diabetes	☐	☐	Hernia	☐	☐	Reaction to cold/heat	☐	☐
Weakness of any part of the body	☐	☐	Q Fever	☐	☐	Paralysis	☐	☐
Gross cysts	☐	☐	Varicose Veins	☐	☐	Other infectious diseases *	☐	☐
Piles or other similar problems	☐	☐	Tendency to bruise easily	☐	☐	Tendency to bleed easily	☐	☐

General Medical Questionnaire

(Applicant)

Medication

Are you taking any injections, tablets or any other forms of medication currently?	Y ☐	N ☐

Have you regularly taken any medication in the past? If so, please list:

1.	2.	3.	4.
5.	6.	7.	8.

Have you ever suffered from adverse effects to chemicals, dust, grease, cement, paint, detergents or other substances?	Y ☐	N ☐
Are you on any current treatment, or received treatment in the past 12 months? i.e. *please describe*	Y ☐	N ☐
1. Physiotherapy		
2. Chiropractic		
3. Massage		
4. Special Diet		

Alcohol Consumption

Do you consume alcoholic beverages?	Y ☐	N ☐

If yes, please estimate your weekly consumption

Beer	Wine	Spirits

Medical Examination

Are you prepared to undergo a pre-employment medical examination by [Company]' nominated doctor?	Yes ☐	No ☐

Declaration

(Applicant)

Declaration

- I declare that the preceding information, supplied on this form, is true and correct to the best of my knowledge. I further consent to carrying out any checks to the above information and forwarding it to a doctor for the purposes of a pre-employment medical examination.
- I have not knowingly withheld any relevant information.
- I have read the position description and that I understand the inherent requirements of the position for which I am submitting an application.
- I further understand that any omission or misinformation provided by me or lies may result in my immediate dismissal should be employed by [Company].
- I acknowledge that the provision of incorrect or misleading information or the omission of any information may negate any future claim for compensable injury or illness.
- I give permission to [Company]' nominated medical officer or doctor to obtain my relevant medical information, clinical records, x-rays and pathology reports from my doctor, so that an assessment of that information can be provided management as necessary.

Signed by employee.....

Date ...../ ...../ .....

Witnessed by ..... [print name]

Signed .....

Date ...../ ...../ .....

Authority for Medical Records

(Applicant)

To:

Address:

I _____ [print name] hereby authorise and direct you to supply to [Company] of [address], any medical information, clinical records, x-rays and pathology reports they may hold.

Dated the _____ day of _____ 2025

Print name .....

Signed by applicant .....

Date ...../ ...../ .....

Witnessed by ..... [print name]

Signed .....

Date ...../ ...../ .....