



# ACTIVE CARE Attendant Care Agency Pty Ltd

## Application for Employment

<b>Position</b>	Personal Carer		
<b>Please tick which position you are applying for</b>	Home Carer		
	Traineeship		
	Other (please describe)		
<b>Surname</b>			
<b>First Name</b>			<b>Title</b> <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss
<b>Address</b>			<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Suburb</b>		<b>Postcode</b>	<b>Date of Birth</b>
<b>Mobile Phone</b>			<b>Home Phone</b>
<b>Email</b>			<b>Date</b>

**In case of emergency please contact:**

<b>Name</b>	<b>Telephone</b>	<b>Relationship</b>
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<b>Country of birth?</b>	<input type="checkbox"/> Australia <input type="checkbox"/> Other (Please Specify)
<b>Other than English, main language spoken at home?</b>	
<b>What is the best time to contact you?</b>	
<b>How did you hear about Active Care?</b>	<input type="checkbox"/> Newspaper <input type="checkbox"/> Internet <input type="checkbox"/> Friend <input type="checkbox"/> Other

**What is the highest level of school you achieved?**

<input type="checkbox"/> Post Secondary	<input type="checkbox"/> Completed Year 9 or equivalent	<input type="checkbox"/> Completed Year 11
<input type="checkbox"/> Completed Year 8 or lower	<input type="checkbox"/> Completed Year 10	<input type="checkbox"/> Completed Year 12
<b>In which year did you complete this level?</b>		<b>Are you currently studying?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

**Please indicate which of the following qualifications you have successfully completed or Security Checks you hold**

<input type="checkbox"/> Working With Children Police Check	<input type="checkbox"/> Certificate IV in any category	<input type="checkbox"/> Certificate I
<input type="checkbox"/> Police Check current	<input type="checkbox"/> Certificate III (or Trade Certificate)	<input type="checkbox"/> Certificates other than the above
<input type="checkbox"/> Level II First Aid	<input type="checkbox"/> Certificate II In any category	

**What Vehicle do you drive?**

<b>Car Engine Type</b>	<input type="checkbox"/> Automatic	<input type="checkbox"/> Manual	<input type="checkbox"/> 6/8 Cylinder	<input type="checkbox"/> 4 Cylinder
<b>Licence Type</b>	<input type="checkbox"/> Full	<input type="checkbox"/> "P" Plate	<input type="checkbox"/> Learners	<input type="checkbox"/> None
<b>Insurance</b>	<input type="checkbox"/> Third Party	<input type="checkbox"/> Full Comprehensive		

**Please indicate any skills you have attained in training**

Area of Care	Task	Competent	Need revision	Unfamiliar	Willing to be trained
<b>Personal Care</b>					
	Sponge wash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Skin checking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Catheter care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Leg bag care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Stretching programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Bowel Care</b>					
	Suppositories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Enema insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Manual stimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Abdominal stimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Transfers</b>					
	Bed rolls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Assisted standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Slide board	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hoist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate which client groups you have previously worked with:			
Clients with a physical disability	<input type="checkbox"/>	Clients with an intellectual disability	<input type="checkbox"/>
Clients with a sight impairment	<input type="checkbox"/>	Clients with an Acquired Brain Injury	<input type="checkbox"/>
Clients with a hearing impairment	<input type="checkbox"/>	Other – Please specify below	<input type="checkbox"/>
Other:			

**Please list your previous Work History for the last 5 years**

PERIOD EMPLOYED		EMPLOYER AND ADDRESS Last or present employer	NATURE OF DUTIES	REASON FOR LEAVING
From	To			
<b>Previous employment</b>				

Work/Professional Referees			
Name:		Phone No:	
Position:		Company Name:	
Name:		Phone No:	
Position:		Company Name:	

Please tick the box beside any condition(s) you have had at any time in your life			
High or low blood pressure	<input type="checkbox"/>	Tennis elbow	<input type="checkbox"/>
Lung problems / Asthma	<input type="checkbox"/>	Arthritis / Rheumatism	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	Mental or nervous troubles	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	Knee problems	<input type="checkbox"/>
Fits / Seizures / Blackouts	<input type="checkbox"/>	Visual impairments	<input type="checkbox"/>
Persistent headaches / Migraines	<input type="checkbox"/>	Stomach problems / Ulcers	<input type="checkbox"/>
Diabetes (sugar)	<input type="checkbox"/>	Hepatitis / Jaundice / Liver trouble	<input type="checkbox"/>
Shoulder problems	<input type="checkbox"/>	Skin disorders / dermatitis	<input type="checkbox"/>
Pain or disability in the neck	<input type="checkbox"/>	Occupational overuse syndrome or repetitive strain injury	<input type="checkbox"/>
Pain or disability in the back	<input type="checkbox"/>		

Please comment on all those marked with an X and indicate what year the injury or condition occurred

Please tick the box beside each activity with which you have difficulty					
Crouching	<input type="checkbox"/>	Lifting	<input type="checkbox"/>	Raising your arms up above head	<input type="checkbox"/>
Standing for two hours	<input type="checkbox"/>	Bending	<input type="checkbox"/>	Pushing	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	Sitting for two hours	<input type="checkbox"/>	Pulling	<input type="checkbox"/>

In your opinion, will the injury/injuries and/or disease/s affect your ability to fulfil the requirements of the position you have applied for. Yes  No

Please indicate how this may occur

Would you need workplace modification or equipment to perform the position applied for? Yes  No

Please give details of the workplace modification or equipment required

Have you made a WorkCover claim in the last five years? Yes  No

Please list the details of any claims made:

Please tick whichever of the following statements is applicable:

- I have suffered no prior injuries that may recur or deteriorate, accelerate or be exacerbated or aggravated by employment.  
OR  
 I have suffered the conditions as indicated above and these may recur or deteriorate, accelerate or be exacerbated or aggravated by the employment.

Please state the injuries / conditions which would be affected

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### Availability

Please tick which type of care work you are interested in:

Casual <input type="checkbox"/>	Part-Time <input type="checkbox"/>	Emergency <input type="checkbox"/>	Full-time <input type="checkbox"/>
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Please tick your availability for work:

	Mon	Tue	Wed	Thur	Fri	Sat	Sun
Morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleepover	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Which suburbs / areas would you be willing to work?

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Please list your personal Interests/hobbies to assist in matching you with clients

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#### PRIVACY INFORMATION

Active Care acknowledges and respects the privacy of individuals. The information on this form is collected for the purpose of processing your application. Active Care does not share your information with any third party, except where required by law.

Applicant Declaration	The information given here is true and correct		
Applicant Name	Date		
Signature			

#### Office use only

Application Processing	Date Undertaken	Induction <input type="checkbox"/>	
<input type="checkbox"/> Interview		Start Date	
<input type="checkbox"/> Reference Check		Complete <input type="checkbox"/> Staff Handbook	Ref <input type="checkbox"/>
Appointed			