EuroSources Pty Ltd t/a
WestSkills WA
ACN 107 581 706
ABN 38 107 581 706

Application for Employment

Suite 1
25 Walters Drive
Osborne Park WA 6017
Telephone: +61 8 9242 7212
Facsimile: +61 8 9446 2088

APPLICATION

Surname:	Given Names:
Address:	
Suburb:	Postcode:
Phone:	Mobile:
Date of Birth:	E-mail: **NOTE: ALL PAYSLIPS WILL BE EMAILED**
Drivers Licence:	Own Transport: □ YES □ NO
Nationality:	□ RESIDENT □ NON-RESIDENT
Emergency Contact:	
Relationship:	Phone:
Do you have a police clearance: □ YES	□ NO
If no, can you get one? □ YES	□ NO

JOB SEEKER DETAILS

Jobseeker ID:		
Are you registered with a Job Network Member:	□ YES	NO
If yes name of agency and location:		
Are you currently employed:	YES	□ NO
If yes (please tick): □ FULL-TIME □ PART-TIME □ CASUAL □ CONTRACT		
Type of work you are seeking: □ FULL-TIME □ PART-TIME □ CASUAL		

FINANCIAL INSTITUTION DETAILS

Financial Institution Name:	
Branch where Account is held:	
Name(s) shown on Account:	
BSB No:	Account No:

EMPLOYMENT HISTORY

Employed from:	To:	
Company:		
Address:		Phone:
Your position:	Reporting to:	
Duties:		Final salary:
Reason for leaving:		

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Company:		
Address:		Phone:
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MEDICAL QUESTIONNAIRE

Do you or have you ever suffered from:	Yes	No	Details
Back injury			
Neck/shoulder/wrist/knee sprains or strains			
Chest or heart disease			
Broken bones			
Infection of nose, throat or ear			
Diabetes			
Asthma			
Skin trouble i.e. Dermatitis or psoriasis			
Eyesight deficiency			
Bone disorder			
Any history of hepatitis			
Hernia or joint problems			
Are you able to pass a drug or alcohol test?			
Any disability or impairment that may affect your ability to work?			
Are you currently on workers compensation?			
Are you currently taking any medication?			
Are you currently undergoing any treatment?			

IMPORTANT NOTICE

Section 79 of the *Workers' Compensation Act 1981* (WA) gives the Workers' Compensation Board discretion to refuse to award compensation which would be payable, where it is proved that the worker has, at the time of seeking or entering employment, willfully and falsely represented him or herself as not having previously suffered the disability, the subject for the claim for compensation. Failure to accurately and completely provide the information requested in the report may lead to the Employer concerned taking disciplinary action against you to and including termination of employment.

PRIVACY AMENDMENT (PRIVATE SECTOR) ACT 2000

Consent Authority

I consent to my employer and employer's insurer and its appointed service provider's collecting personal information, inclusive of sensitive information such as medical information, about me and using it for the purpose of assessing and managing my workers' compensation claim including determining liability and whether my claim is true. This consent extends to my employer and employer's insurer disclosing my personal information, inclusive of sensitive information, to other insurers, medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purpose of assessing and managing my current or subsequent claim. My personal information, inclusive of sensitive information, may also be disclosed as required or permitted by law. I also consent to my employer and employer's insurer disclosing my personal details to Work Cover WA, which is authorized to use this information to fulfill its functions and obligations under the *Workers' Compensation and Rehabilitation Act 1981* (WA).

I certify that all this information is true to the best of my knowledge. I have read all the information and understood all the company's terms and conditions of employment. I authorise **WestSkills WA** to obtain my personal information from my doctor and where applicable the insurance company for any workers' compensation a the time. I understand that if I have falsified any work details or medical details my employment will be terminated. I will comply with all the client/company policies and safe work and observe the requirement of the relevant Occupational Health and Safety Act and Regulations.

SIGNATURE OF APPLICANT	PRINT NAME
SIGNATURE OF WITNESS	PRINT NAME
Date Signed:	