CHALLENGE FOUNDATION

GOULBURN INCORPORATED

1

Application for Employment

Position applied for

Last Name | First Name

Address

Postcode

Telephone | Date of Birth | Age

Country of Birth | Preferred Language

Drivers Licence No. | State | Class | Expiry Date

Emergency Contact | Relationship | Emergency Contact Telephone

Emergency Contact Address

Postcode

Are you legally entitled to work in Australia?

- ☐ Yes, I am an Australian/New Zealand citizen or permanent resident
- ☐ Yes, I hold a valid work VISA

  TYPE: _____ EXPIRY DATE: _____
- ☐ No

***Please note that you will be asked to provide evidence of citizenship, permanent residency, or working VISA*

Education, Training and Qualifications

Name of Institution	Course Name	Year Completed	Qualification Achieved

***Please note that you will be required to provide copies of any education awards, training certificates, licenses or qualifications listed above, for verification purposes*

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Application for Employment

Details of Previous Employment or Work Experience

Dates	Company	Position	Duties	Reason for leaving	Contact Details

Have you been previously employed by this company? Yes ☐ No ☐

If so, Dates Employed: _____ Job Position: _____ Reasons for Leaving: _____

List Three Professional Referees

Name	Company	Address	Position	Telephone

***Please note that by providing the contact details of the above professional referees, you are also providing your consent for us to contact the professional referee to discuss your suitability for this position. Where possible, the professional referee should be someone who knows you in an work capacity.*

Statement

In signing this Application for Employment, I solemnly declare that each and every answer above is true to the best of my knowledge and belief. I understand that any false or misleading information may result in termination of employment.

Signature _____ Date _____

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WAGES BANK DETAILS & SUPER

Name:- .....

Bank BSB # .....

Bank Account # .....

Bank Name:- .....

Superannuation Fund name:- .....

Super Fund Account # .....

Super Fund USI # .....

Tax File # .....

Signature:- .....

Date:- .....

20 Marys Mount Rd Goulburn NSW 2580
PO Box 36, Goulburn NSW 2580
Phone: 4821 2928
ABN 52 491216 766

CHALLENGE FOUNDATION

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HEALTH QUESTIONNAIRE

(to be completed by candidate)

Information:

Surname:	Given name(s):
Address:	
Date of birth:	Phone:
Driver licence number:	State of issue:

Employer information:

Employer:	
Address:	
Contact name:	Phone:
Contact email	

Instructions:

Please answer the questions by ticking the appropriate box and providing details as requested. If you are not sure what a question means, leave the answer blank and the health professional will help you. The health professional will ask you additional questions during the assessment.

Please bring with you to the assessment:

- A list of current prescription, non-prescription and complementary medicines
- Glasses/contact lenses and hearing aids if you use them
- Disease management plans (e.g. sleep disorder management plan, diabetes management plan)

On completion of the questionnaire, you will be asked to sign a declaration to confirm the accuracy of your responses. You will also be asked to provide your consent if the health professional requests to make contact with your treating health professional(s) to help clarify your medical management as required to determine fitness to drive.

Questions:

1.	Are you currently attending a health professional for any illness, injury or disability?	☐ No ☐ Yes
2.	Are you taking any prescription, non-prescription or complementary medicines?	☐ No ☐ Yes

If **YES** to Question 1 or 2 please provide brief details:

Health professional comments:

3. Do you suffer from or have you ever suffered from any of the following:

3.1	High blood pressure	☐ No ☐ Yes	**3.11**	Stroke	☐ No ☐ Yes

3. Do you suffer from or have you ever suffered from any of the following:

3.2	Heart disease	☐ No ☐ Yes	**3.12**	Dizziness, vertigo, problems with balance	☐ No ☐ Yes
3.3	Chest pain, angina	☐ No ☐ Yes	**3.13**	Memory loss or difficulty with attention or concentration	☐ No ☐ Yes
3.4	Any condition requiring heart surgery	☐ No ☐ Yes	**3.14**	Other neurological or neurodevelopmental disorder	☐ No ☐ Yes
3.5	Palpitations / irregular heartbeat	☐ No ☐ Yes	**3.15**	Neck, back or limb disorders	☐ No ☐ Yes
3.6	Abnormal shortness of breath	☐ No ☐ Yes	**3.16**	Double vision, difficulty seeing	☐ No ☐ Yes
3.7	Diabetes	☐ No ☐ Yes	**3.17**	Colour blindness	☐ No ☐ Yes
3.8	Head injury, spinal injury	☐ No ☐ Yes	**3.18**	Hearing loss or deafness or had an ear operation or use a hearing aid	☐ No ☐ Yes
3.9	Seizures, fits, convulsions, epilepsy	☐ No ☐ Yes	**3.19**	A psychiatric illness or nervous disorder	☐ No ☐ Yes
3.10	Blackouts or fainting	☐ No ☐ Yes			

Health professional comments:

4.	Have you ever had any other serious injury, illness, disability, operation or accident or been in hospital for any reason? Including any previous workplace injuries resulting in a Workers compensation insurance claim?	☐ No ☐ Yes

Please describe:

Health professional comments:

5. Sleep

5.1	Have you ever been tested for a sleep disorder or been told by a doctor that you have a sleep disorder, sleep apnoea or narcolepsy?	☐ No ☐ Yes
5.2	Are you aware or have you been told that you snore loudly?	☐ No ☐ Yes
5.3	Has anyone told you that your breathing stops or is disrupted by episodes of choking during your sleep?	☐ No ☐ Yes

5.4	How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? *This refers to your usual way of life in recent times. If you haven't done some of these things recently try to work out how they would have affected you.*	would never doze off **(0)**	slight chance of dozing **(1)**	moderate chance of dozing **(2)**	high chance of dozing **(3)**
a	Sitting and reading	☐	☐	☐	☐
b	Watching TV	☐	☐	☐	☐
c	Sitting inactive in a public place (e.g. a theatre or a meeting)	☐	☐	☐	☐
d	As a passenger in a car for an hour without a break	☐	☐	☐	☐
e	Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
f	Sitting and talking to someone	☐	☐	☐	☐
g	Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
h	In a car, while stopped for a few minutes in the traffic	☐	☐	☐	☐

Health professional comments:

6. Alcohol and other drugs

6.1	Have you ever sought assistance for alcohol or substance use issues?	☐ No ☐ Yes

6.2	**Please circle the answer that best describes your situation.**	**(0)**	**(1)**	**(2)**	**(3)**	**(4)**
a	How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
b	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 to 5	5 to 6	7 to 9	10 or more
c	How often do you have six or more drinks on one occasion?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
d	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
e	How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
f	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
g	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
h	How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
i	Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year
j	Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

Health professional comments:

Other drugs

6.3	Do you currently use illicit drugs?	☐ No ☐ Yes
6.4	Do you use any drugs or medications not prescribed for you by your doctor?	☐ No ☐ Yes
	Please describe:	
6.5	Have you tested positive for drugs or alcohol in the period since your last assessment?	☐ No ☐ Yes

Health professional comments:

Declaration – accuracy and completeness of information provided

To the best of my knowledge the answers given above are accurate and complete:

Signature of candidate

Date

Signature of examining doctor

Date

Candidates declaration

I have read and understood the statement concerning the health information provided in this document.

Signature of Candidate

Date

CHALLENGE FOUNDATION

GOULBURN INCORPORATED

Assessing fitness to drive

2022

Health Assessment for Commercial Vehicle Driver

CLINICAL ASSESSMENT RECORD

Driver information:

Surname:	Given name(s):
Address:	
Date of birth:	Phone:
Driver licence number:	State of issue:

Employer information:

Employer:	
Address:	
Contact name:	Phone:
Contact email	

Nature of driving duties (type of vehicle, hours and distances of driving, purpose of driving):

CLINICAL ASSESSMENT:

The patient has been assessed to the following AFTD standard:

☐ Commercial vehicle driver

Health assessment history

Date of driver's last fitness to drive assessment Date: ☐ Not applicable or not known

Health professional comments:

1. Vision

1.1 Visual acuity (refer AFTD, page 201, 210)

Are glasses or contact lenses worn? ☐ Yes ☐ No

	R	L	Both
Without Correction	6 /	6 /	6 /
With Correction	6 /	6 /	6 /

Meets criteria ☐ Without correction ☐ With correction

Does not meet criteria ☐

1.2 Visual Fields ☐ Normal ☐ Abnormal (refer AFTD, page 203-204, 209)

Health professional comments:

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GOULBURN INCORPORATED

Job Description and Physical Requirements

Purpose

Our organisation has a duty of care to provide and maintain a safe working environment, so far as is practicable, and to ensure employees are not exposed to hazards. The purpose of this form is to provide detailed information about the physical requirements of a specific job position. This information may be used in conjunction with:

- pre employment medical information to assist in determining your physical and medical suitability for the role
- medical information relating to injury or illness (whether work-related or not) to assist in determining whether we can accommodate an injured or ill worker on a restricted return to work
- medical information to determine whether aids or equipments can be provided that may assist in the performance of work duties for injured, ill or impaired workers

In the case of injury, illness or impairment to an employee, this form may be provided to treating Doctors and health practitioners to assist in determining capacity for work and developing a return to work program.

. pre-employment purposes, this form should be read carefully and fully understood before completing the pre-employment medical questionnaire.

Job Description

Position Title

Job Description and Duties

Required Education and Training

Hours Per Day and Days per Week