

CENTURY ORCHARDS

Employment Application

Date: / /

Name: _____ D.O.B _____

Position applied for: _____

Address: _____

Postal: (If different from above) _____

Telephone: _____

Licenses: _____

Education: (Highest level achieved) _____

Qualifications: _____

Referees: 1 _____ Phone _____

 2 _____ Phone _____

 3 _____ Phone _____

Century Orchards Pty Ltd

ABN 69 079 603 204

Orchard Office: P O Box 894, Loxton, South Australia, 5333

Telephone 08 8584 4777, facsimile 08 85844888

Incorporated in South Australia

CENTURY ORCHARDS

References

Name: _____

Are we able to contact your previous employer Yes/No Current employer Yes/No

Employer	Phone number	Position	Dates commenced/finished	Duties

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Section 19 of the Occupational Health, Safety and Welfare Act 1986 stipulates our Company has a duty of care to each employee to ensure so far as is reasonably practical that the employee is, while at work, safe from injury and risks to health. To avoid inadvertently placing you in a risk situation, we need to ensure you are physically capable of performing the tasks associated with any job assignment that you would normally be required to do. To satisfy our responsibility, please answer the following questions and sign the authority.

Have you ever had any concerns with the following: (Please circle yes or No)

Hearing difficulties	Yes/No	Back or neck problems	Yes/No
Sight difficulties	Yes/No	Working at heights	Yes/No
Lifting (any weight limitations)	Yes/No	Pushing/Pulling or reaching	Yes/No
Bee allergy	Yes/No	Climbing (eg; ladders/stairs)	Yes/No
Sitting/Standing for periods in one spot	Yes/No		

If you answered Yes to any of the questions please provide details:

Would you be prepared to undertake a medical examination Yes/No

Have you any pre-existing injury or disability which may put you, or the health and safety of any other person at risk in any work situation (eg asthma, skeletal weakness, muscular deficiency)? Yes/NO

If you answered Yes please provide details:

Sign: _____

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Have you had any work injuries or WorkCover claims, If Yes please supply the following:

Year of disability: _____

Nature of injury/Illness: _____

Duration of disability: _____

Current restrictions: _____

Section 112(2) of the Workers rehabilitation and Compensation Act 1986 allows disclosure of WorkCover information by the Corporation and/or its Agents if it is made with the consent of the person to whom the information relates.

Do you consent to us confirming the above WorkCover details: Yes/No

I _____
(Full name)

Of _____
(Full address)

Date of birth _____ Telephone _____

Authorise the WorkCover Corporation to release any and all information (date and nature) relating to my workers Compensation claims held on the WorkCover Corporation database. I understand by signing this authority in accordance with section 112 (2) (c) of the Workers Rehabilitation and Compensation Act 1986 as amended, it allows the WorkCover Corporation to release all information (date and nature) relating to any workers compensation claims I have lodged with the Corporation.

Signature of Applicant

Date

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Office use only

	Referee	Date contacted	Comments
1			
2			
3			

	Employer	Date contacted	Comments
1			
2			
3			
4			

Comments _____

Signed _____

Interview Yes/No

Accept/Decline