

APPLICATION PACK CHECKLIST

Instructions

Please tick if the relevant section is completed and included:

- Employment Application
- WorkCover Declaration
- Immunisation Record Form
- Record of Vaccinations Received
- Health Assessment Form
- Consent to check and release National Police Record

If you have completed a Police Check in the last six months please forward a certified copy of the document with your completed Employment Pack.

If you have not completed a Police Check in the last 6 months, please complete the attached form and forward to the address listed on the second page. It is your responsibility to cover any charges for this check. When Victoria Police has completed your check they will forward the documentation to you. Please forward a certified copy of your check to NPT Group with your completed Employment Pack.

Please return the attached forms with certified copies of your qualifications, drivers licence and police check. Documents will not be accepted unless they have been certified. Details of who can certify your documents is listed on page 3, section F, of the police check form.

Please complete the attached paperwork and return to:

Human Resources Officer
NPT Group
20-22 Hardner Road
MT WAVERLEY VIC 3149

EMPLOYMENT APPLICATION

Name: _____ DOB: ___ / ___ / ___

Address: _____

Home Ph: _____ Mobile: _____

Current or Anticipated Qualifications:

_____	Date Received: ___ / ___ / ___
_____	Date Received: ___ / ___ / ___
_____	Date Received: ___ / ___ / ___

Position Applying for: _____

Type of Employment: Casual Part time Full time _____ hours/week

Please attach to this page:

1. Your CV, if not already submitted
2. Certified copies of your qualifications and academic record
3. Certified copy of your drivers licence
4. Certified copy of your Police Check.

WORKCOVER DECLARATION

I, (Full Name) declare that the information filled in below is true and correct.

1. Do you currently have a WorkCover claim? Yes No
 If yes, please give details.

2. Have you had a WorkCover claim in the last 5 years? Yes No
 If yes, please give details.

3. Do you have any medical problems that we should be made aware of that might affect your capacity to fulfil the duties as described in your job description?
 If yes, please give details. Yes No

4. Can you drive a manual vehicle? Yes No

Signature: _____ Date: ____ / ____ / ____

IMMUNISATION RECORD

PRIVATE AND CONFIDENTIAL

SURNAME: _____ OTHER NAMES: _____

ADDRESS: _____

_____ POSTCODE: _____

PHONE NO: _____ MOBILE: _____

Yes No

I give Consent to the NPT Group to obtain information from me regarding my immunisation status. I understand that the information provided will be kept confidential and that all identified information will not be disclosed to a third party unless my next of kin or I give consent.

Signature

_____/_____/_____
Date

Yes No

I do not wish to disclose my vaccination status to the NPT Group at this time.

Signature

_____/_____/_____
Date

RECORD OF VACCINATIONS RECEIVED

	Yes	No	Unsure	State	Year
Hepatitis B Vaccine or serology complete course Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Adult Diphtheria, Tetanus, and Pertussis Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Polio Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Measles, Mumps Rubella Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis A Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Varicella History (chicken pox) (exposure /disease or injections) Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Varicella Serology Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Influenza Vaccine Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other Vaccines Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

MEDICAL REPORT

ASSESSMENT OF FITNESS TO DRIVE

To be completed by health professional

Patient/Applicant Details (Please print)

SURNAME: _____ OTHER NAMES: _____

ADDRESS: _____

_____ POSTCODE: _____

DATE OF BIRTH: ____ / ____ / ____ DRIVERS LICENCE No: ____--_____

Were you familiar with the patient's medical history prior to examination? Yes No

I certify that I have examined the above mentioned patient (who intends to drive commercial passenger vehicles and/or buses) in accordance with the relevant National Medical Standards for Commercial Vehicle Drivers as set out in Assessing Fitness to Drive 2003. In my opinion the subject of this report (please tick the most appropriate box):

- Meets the relevant medical criteria for an unconditional licence and requires no further assessment. **(No further information required)**
- Does not meet the medical criteria for an unconditional or a conditional licence
- Does not meet the medical criteria for an unconditional licence but may be suitable for a conditional licence based on opinion (and additional details attached as required)
Note: A conditional licence will not be issued unless adequate supporting information is provided by the examining health professional. Examining doctor to attach details of:
 1. Criteria not met and other relevant medical details.
 2. Proposed restrictions to licence (if appropriate)
 3. Suggestions for management and periodic review interval (conditional licence)
- Requires appropriate specialist assessment
Examining health professional to note type of specialist recommended/referred or type of practical driver assessment required.
- Requires practical driving test.
- Requires Occupational therapist assessment
- Previously unlicensed or on conditional licence but condition has now improved so as to meet criteria for a conditional or unconditional licence.
Examining health professional to note: Criteria previously not met; the response to treatment and prognosis; duration of improvement; other relevant information including consideration of the driving task

PHYSICAL ASSESSMENT

Date of examination: _____ / _____ / _____

BP: _____ Respirations: _____ Pulse: _____

Heart Rate/Rhythm: (Please circle) Regular / Not Regular

Chest: (Please Circle) Clear / Not Clear

Eye Sight Test (Snellen Code)

The minimum acceptable standard is 6/12(Snellen) in each eye separately.

	Unaided	Aided
Left	6/	6/
Right	6/	6/

HEALTH PROFESSIONAL'S DETAILS (Please Print)

Reporting Professional's Name: _____

Practice Address: _____

Telephone: () _____ Fax: () _____

Signature: _____ Date: ____ / ____ / ____

Further comments on medical condition(s) affecting safe driving are attached.

Note : The publication *Assessing Fitness to Drive 2003* is available from austroads on tel.(02) 9264 7088 or via the web at www.austroads.com.au.

CONSENT OF PATIENT/APPLICANT

I, the above named patient and applicant for a driver's certificate, consent to the examining practitioner providing information to the NPT Group or Vic Roads. I understand that I shall be responsible for any medical expenses incurred in connection with the compilation of the above medical report.

Applicant's Signature: _____ Date: ____ / ____ / ____

HEALTH ASSESSMENT

PRIVATE AND CONFIDENTIAL

This information is to provide the Occupational Health Practitioner with health data, so that your health can be monitored and maintained during the course of your employment. This information is confidential and will not be divulged to any other person within the company without your written permission.

SURNAME: _____ OTHER NAMES: _____

ADDRESS: _____

_____ POSTCODE: _____

PHONE NO: _____ MOBILE: _____

DATE OF BIRTH: ____ / ____ / ____ AGE: ____ SEX: MALE / FEMALE

POSITION SOUGHT: (If appropriate) _____

EMERGENCY CONTACT NAME: _____ TELEPHONE: _____

HEALTH STATUS

1. Are you receiving any treatment for a major illness at present, or have you received treatment in the last 5 years? If yes list below. (Do not include minor ailments like Flu)

2. What medications, if any have you taken on a regular basis in the last 12 months.

	Yes	No	Name of Medication
Anti-convulsion medicine eg for epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aspirin/Panadol/other painkillers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cold, cough medicine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood thinning medicine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cortisone	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart tablets	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure medicine	<input type="checkbox"/>	<input type="checkbox"/>	_____

Insulin, diabetic tablets _____

Sleeping pills, sedatives Stimulants _____

Anti-depressants _____

Others, (give details) _____

3. Have you ever had any serious illnesses, operations or injuries If yes please state details (serious is defined off work for more than 2 weeks and/or requiring hospitalisation.)

_____ Date / /

_____ Date / /

_____ Date / /

4. Have you ever suffered any work related injuries or illnesses? If yes please give details.

5. List any permanent condition or injury, such as the loss of a finger, or toe, eye, fractures, scars etc.

6. Have you been involved in a motor vehicle accident? If yes, give details of any injuries sustained and dates:

_____ Date / /

_____ Date / /

_____ Date / /



7. Have you had any of the following:	Yes	No	If yes, please give details:
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye or vision problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	_____
A frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema/bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pleurisy/pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath or wheezing:	<input type="checkbox"/>	<input type="checkbox"/>	_____
while walking	<input type="checkbox"/>	<input type="checkbox"/>	_____
While climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	_____
At night	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pains in chest/angina	<input type="checkbox"/>	<input type="checkbox"/>	_____
A head injury/concussion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions, seizures, migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nervous trouble, anxiety, depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heartburn, indigestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any joint injuries (neck, wrist, arm, fingers, shoulder, hip, knee, ankle)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back pain, stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	_____



[PRE-EMPLOYMENT PACK]

[Human Resources Form]

NPT GROUP

- Foot problems _____
- Asthma/hay fever _____
- Hepatitis _____
- Hernia, rupture, bowel disease _____
- Varicose veins, clots or blocked arteries _____
- Allergy to chemicals or medications _____
- Other allergies _____
- Other medical issues _____

- 8. Do you smoke cigarettes?
- 9. Do you wear glasses or contact lenses?
- 10. Do you wear a hearing aid?

I _____ declare that all information supplied is true and correct to the best of my knowledge and belief.

Signature

_____/_____/_____
Date