

## 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.

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

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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

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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
<b>Hepatitis B</b> Vaccine or serology complete course Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<b>Adult Diphtheria, Tetanus, and Pertussis</b> Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<b>Polio</b> Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<b>Measles, Mumps Rubella</b> Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<b>Hepatitis A</b> Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<b>Varicella History (chicken pox) (exposure /disease or injections)</b> Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<b>Varicella Serology</b> Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<b>Influenza Vaccine</b> Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<b>Other Vaccines</b> 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](http://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.

	<b>Yes</b>	<b>No</b>	<b>Name of Medication</b>
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:	<b>Yes</b>	<b>No</b>	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   \_\_\_\_\_

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- 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