

Employment Application Form

First Name(s): _____ **Surname** _____

Address: _____

Date of Birth _____ **Marital Status** _____

Telephone Nos Home _____ **Mobile** _____

Position you are applying for _____

Education: (Including Trade Qualifications and Continuing Education) Enter if not of C.V.

Name of College or Institution _____ **From** _____ **To** _____ **Subjects Taken and Qualifications** _____

Employment History: (Start with the most Recent Position) **Enter if not on C.V**

Name of Employer	Address/Telephone Numbers	Length of Service - dates employed	Position held	Reason for Leaving

Employment References: at least three please

Name	Phone No	Company Name
<u>1.</u>		
<u>2.</u>		
<u>3.</u>		
<u>4.</u>		

General

(tick as required)

Yes

No

Do you object to enquires of your present employer?		
Do you object to enquires of your past employers?		
Are you prepared to work extra hours- above 45 hours per week?		
Are you prepared to work Saturdays		
Are you prepared to handle all product normally used in this industry?		
Do you have a current and clear drivers licence?		
Please state what classes of Drivers Licences you hold.		
Have you been convicted of a Criminal Offence? If yes give details:		
Do you have any commitments at this time which would you prevent you from attending your place of employment in the future? If yes give details:		
Do you have any part time or secondary employment (Voluntary or paid)		
Do you know any one in this industry? If yes give name:		

Medical

Have you had any previous illnesses or injuries?

Yes/No

If yes give dates and details _____

Have you suffered from (Tick where appropriate)

<input type="checkbox"/> Black outs/Fits	<input type="checkbox"/> Allergies
<input type="checkbox"/> Asthma	<input type="checkbox"/> Headaches
<input type="checkbox"/> Hernia	<input type="checkbox"/> Rheumatism/Arthritis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> R.S.I.
<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Ear ache/Deafness
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Back Injury/Strain
<input type="checkbox"/> Do you wear glasses or contact lenses	<input type="checkbox"/> Are you on medication
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Drug Abuse

If on medication give details _____

If you have suffered or currently have back injury, strain or pain give details: _____

How long have you had the back pain, strain, injury? _____ months/years

Did this back injury, pain, strain happen in

- i) In your current job _____
- ii) In another job _____
- iii) Work accident _____
- iv) Injury outside work _____
- v) Medical reason _____

What treatment have you had for this back pain, strain, injury? _____

Hobbies/Sports _____

Why should Spraggs Bricklayers Limited employ you? _____

Why have you chosen to work in the Bricklaying/Blocklaying industry? _____

I _____ declare this application is a true and correct record and understand that if any of the information is false or material fact suppressed I may not be accepted or if I am employed, I may be dismissed without warning or notice.

Date _____ **Signature** _____

Thank you for taking the time to complete this application form.

Please post to:

Or fax to 0064 3 541 0076

Spraggs Bricklayers Ltd

PO Box 3563

Richmond

Nelson

New Zealand