

All correspondence to: PO Box 3036 Robina QLD 4230 GOLD COAST AUSTRALIA
Head Office: 43 Commerce Drive Robina QLD 4226 GOLD COAST AUSTRALIA

TRANSIT AUSTRALIA GROUP

APPLICATION FOR EMPLOYMENT

*The information supplied in this document will remain strictly confidential between the applicant and this Company.
This form must be completed in the applicant's own handwriting.*

PERSONAL DETAILS

Position Applied For:			Date:
Surname:	Given Names:		Preferred Name:
Present Address:			Home Ph:
Suburb:	State:	Post Code:	Mobile Ph:

EMERGENCY CONTACT

Name:	Home / Business Address:
Contact No:	Relationship:

LICENCE DETAILS

Do you hold a current drivers licence? <input type="checkbox"/> Yes <input type="checkbox"/> No	Licence No:	Class:
	Expiry Date:	State of Issue:
Do you hold a current drivers authority? <input type="checkbox"/> Yes <input type="checkbox"/> No	DA No:	Class:
	Expiry Date:	State of Issue:

Please attach a photocopy of your drivers licence and drivers authority (if applicable)

Do you have any convictions, traffic endorsements on points? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please give details:

EDUCATION AND TRAINING

School, College, Institute, University etc:		Location:	
From:	To:	Standard Reached / Qualifications Obtained:	
Certificate Training / Institution:		Location:	
From:	To:	Certificate obtained:	Copy Attached: Y <input type="checkbox"/> N <input type="checkbox"/>
Apprenticeship:	Employer:	Location:	
Other qualifications, training or special skills:			

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HEALTH				
Do you have / have you had trouble with your:	Back / Neck <input type="checkbox"/> Yes <input type="checkbox"/> No	Wrist / Elbows <input type="checkbox"/> Yes <input type="checkbox"/> No	Ankles / Knees <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Hearing <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____	
Have you ever injured yourself at work or suffered an industrial disease? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have any physical impairment which would prevent the wearing of personal protective equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "yes" to any questions above, please give details:				
EMPLOYMENT HISTORY				
Company Or Employer Name	Position Held	From	To	Reason for Leaving
Do you have copies of references from these employers? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If necessary are you willing to:				
Work overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No		Work night shift? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Work weekends? <input type="checkbox"/> Yes <input type="checkbox"/> No		Work split shifts? <input type="checkbox"/> Yes <input type="checkbox"/> No		
APPLICANTS DECLARATION				
I declare that all statements which I have made on this form are true to the best of my knowledge and belief, and understand that any misstatement of material facts may affect the success of this or any future employment application with this Company. I further understand that failure to provide information or falsely stating any information may result in termination of employment. I further understand and accept that my roster may be changed at any time with due regard to relevant awards and/or enterprise agreement conditions. I also confirm that I am able to maintain the required standards of safety, courtesy and neatness at all times and observe all rules and policies of the Company including due care and responsibility of Company property, equipment and monies. I agree to actively participate in random breath testing as required.				
Signature:			Date:	
OFFICE USE ONLY				
Start Date:	Classification:	Award:	Base Wage:	
Special Conditions (if any):				