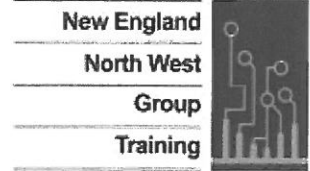


Application Form (Apprentice or Trainee)

Version 12

Ph: (02) 6762 6755
 Fx: (02) 6762 6226
 Email: nenwgt@hvtc.com.au
 PO Box 3323
 West Tamworth, NSW, 2340

A division of:
 Hunter Valley Training Company



Please note: that you may be required to complete a Selection Test at a date to be determined, should your application be considered. Kindly attach a copy of your Resume including copies of School, TAFE reports and results, etc. Also note that you will need to re-apply after 12 months from the date of this application.

Position Applying for: (please tick)

Apprenticeship

Traineeship

Please nominate, in order, your choice of Apprenticeship or Traineeship (e.g. Business, Electrical, etc.):

1. _____
2. _____
3. _____
4. _____

Personal Information

Family Name: _____ Given Names: _____

Date of Birth: _____ Age: _____ Male Female

Country of Birth: _____ Are you an Australian Citizen? Yes No

Are you of Aboriginal Torres Strait Islander Descent? Yes No

Residential Address: _____

Suburb/Town: _____ State: _____ Postcode: _____

Postal Address: _____

Suburb/Town: _____ State: _____ Postcode: _____

Phone Number: _____ Mobile: _____

E-mail Address: _____

Education / Prior Achievements

Highest Level of School Education Achieved (e.g. year 12): _____

School Attended: _____ Year you Left School? (e.g. 2010): _____

Have you commenced/completed any courses (eg. TAFE, Pre-vocational, VET, PA, Apprenticeship, or Traineeship)? Yes No

If yes please complete the table below:

Course Name	Course Date	Course Location	Level Achieved

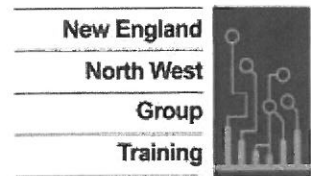
Applicant Initials: _____

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Employment History

Have you previously been employed? Yes No

If yes, please provide details below:

Employer Name	Job Title	Start Date	Finish Date

Please include below two referees (if you have previously been employed, one of these must be a work reference):

Name	Company	Phone

Other Information

Are you registered with a Job Network Agency? Yes No

If so, which organisation? _____ Location: _____

Do you have a current driver's licence? Yes No License Number: _____ Class: _____

Do you have your own transport? Yes No Type of Transport: _____

Do you have an OHS Construction Induction Certificate? Yes No

OHS CIS No: CGI _____

Please note: We are an EEO Employer. We are asking for the following information so that we know how best we can accommodate your needs if you are appointed to a position.

Do you have a disability, or are you aware of any circumstance regarding your health, which might interfere with your ability to perform the duties of the position for which you are applying? Yes No

If yes, please provide details: _____

Are you colour blind? Yes No

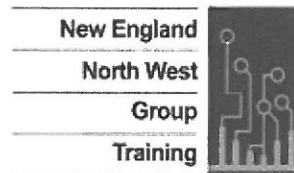
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Emergency Contact Details

Surname: _____ Given Names: _____

Address: _____

Suburb/Town: _____ State: _____ Postcode: _____

Phone (Home): _____ Phone (Work): _____ Mobile: _____

Relationship to Applicant: _____

How Did you Find out About our Company?

Newspaper Radio TV

If so, which paper/station? _____

Internet School Yellow Pages Job Network Agency Word of Mouth

Other (please specify): _____

Authorisation:

As a condition of my application, I authorise investigation of all statements contained herein and I understand that misrepresentation or omission of facts called for is just cause for dismissal.

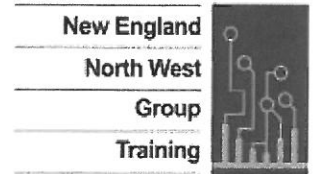
I understand that if I will be working on a construction site, it is a condition of employment with Hunter Valley Training Company that I have attended a WorkCover OHS Construction Induction course and can provide an OHS Construction Induction Certificate to verify my attendance PRIOR to commencing my apprenticeship/traineeship.

Applicant's Signature: _____ **Date:** _____

Personal Health Questionnaire

Version 11

Ph: (02) 6762 6755
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Name: _____

Date: _____

Date of Birth: _____

Position Applied for: _____

This information is required so that if you have a particular medical condition or restriction you will be placed where you will not aggravate your condition, or cause danger to yourself or others.

Answer the following questions (tick the boxes)	Yes	No
1. Have you experienced any serious illness, discomfort or limitation of activity to any part of your body?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, has this required ongoing treatment?	<input type="checkbox"/> *	<input type="checkbox"/>
2. Have you had a serious injury (motor vehicle, sporting or other)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, has this required ongoing treatment?	<input type="checkbox"/> *	<input type="checkbox"/>
If yes, are you in the process, or do you intend to make a claim for this injury?	<input type="checkbox"/> *	<input type="checkbox"/>
3. Have you ever claimed workers compensation or been off school or work for an extended period of time?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, has this required ongoing treatment?	<input type="checkbox"/> *	<input type="checkbox"/>
4. Are you prepared to take a drug test?	<input type="checkbox"/>	<input type="checkbox"/> *
5. Do you use medication/drugs – occasionally or regularly? (Whether prescribed or otherwise)	<input type="checkbox"/> *	<input type="checkbox"/>
If yes, please supply details: _____ _____		

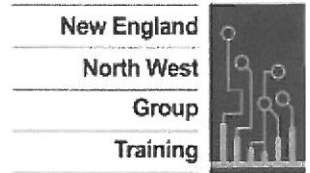
**Do you suffer from/have you ever suffered from any of the following?
 If you answer YES, please supply details on page 2.**

Injury/Condition	Yes*	No
Eye disorders or trouble	<input type="checkbox"/>	<input type="checkbox"/>
Colour blindness	<input type="checkbox"/>	<input type="checkbox"/>
Deafness, hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Allergy of any kind (eg: hay fever, latex, anaphylaxis etc)	<input type="checkbox"/>	<input type="checkbox"/>
Skin trouble (dermatitis)	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease or disorder, including asthma	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain, blood pressure, heart complaint	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>

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Injury/Condition	Yes*	No
Head injury, concussion, paralysis or partial paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells, blackouts, dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Phobias (eg. Confined spaces, being at heights)	<input type="checkbox"/>	<input type="checkbox"/>
Nerves, nervous breakdowns, anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression, depressive illness	<input type="checkbox"/>	<input type="checkbox"/>
Mental disorder, psychosis	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones, fractures or dislocations	<input type="checkbox"/>	<input type="checkbox"/>
Joint sprains or injuries	<input type="checkbox"/>	<input type="checkbox"/>
Back trouble, injuries or weakness, disc disorders	<input type="checkbox"/>	<input type="checkbox"/>
Surgical operations	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Other, please provide details below	<input type="checkbox"/>	<input type="checkbox"/>

Further details (please attach additional pages if more space is required)

Note: A pre-employment functional capacity assessment may be required as part of the recruitment process.

Declaration

I declare that the above information is, to the best of my knowledge, true and correct. I know that if I supply any false or misleading information in answer to these questions or during any suitability assessment, I will, if accepted for employment, be liable to dismissal without notice.

Signature: _____ **Date:** _____

*Office Use Only

Date Discussed with Safety Services: _____

Agreed Action: _____

Updated in Jobready: _____ (initial)