



# SEALANES

FOOD SERVICE, SEAFOOD DISTRIBUTORS & SHIP SUPPLIERS

178 Marine Terrace, South Fremantle WA 6162 – PO Box 658, Fremantle WA 6959

Reception 08 9432 8888

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## EMPLOYMENT APPLICATION

### POSITION SOUGHT

Full time  Part- Time  Casual

Initial preferred working days and indicate whether you are willing to perform shift work.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Shift Work yes or no

### PERSONAL DETAILS

Surname \_\_\_\_\_ Given Names \_\_\_\_\_

Street Address \_\_\_\_\_ Suburb \_\_\_\_\_ Post code \_\_\_\_\_

Telephone \_\_\_\_\_ Mobile \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Postal Address \_\_\_\_\_ Suburb \_\_\_\_\_ Post code \_\_\_\_\_

### NEXT OF KIN (for contact in emergency)

Surname \_\_\_\_\_ Given Names \_\_\_\_\_

Address \_\_\_\_\_ Suburb \_\_\_\_\_

Relationship \_\_\_\_\_ Telephone \_\_\_\_\_ Mobile \_\_\_\_\_

### SECONDARY EDUCATION

School	Standard Attained	Year Completed

### UNIVERSITY/TERTIARY/APPRENTICESHIP

Institution	Qualification	Year Completed

Do you have a current Forklift Licence? \_\_\_\_\_ What class of driving licence do you hold? \_\_\_\_\_

Do you have a current National Police Clearance? \_\_\_\_\_ If yes, please attach.

### PRE EMPLOYMENT MEDICAL QUESTIONNAIRE

The purpose of this questionnaire is to ensure that the applicant's physical and other related abilities are matched to the medical and fitness standards for the particular duties of the job. Collection of this information will enable Sealanes to assist in the prevention of exacerbation of a medical condition, to ensure the applicant is able to productively carry out the duties of the position safely, and to ensure there is no risk to the safety of other workers, the general public, equipment or products.

The Pre Employment Medical Questionnaire is treated as a confidential document. The personal information held in this form is stored securely and access is restricted to authorised personnel only. Sealanes will retain this form on file and reserves the right to refer the information in the event of an accident, sickness, injury or claim for workers compensation.

**Failure to disclose any relevant information relating to your health may impact upon any future claim to workers compensation (pursuant to S79 Workers Compensation and Injury Management Act 1981).**

Have you lost time from work in the last 12 months due to illness or injury? \_\_\_\_\_

Are you currently taking or have you taken medication in the past two years? \_\_\_\_\_

Do you have any known allergies? If yes, please state allergies and any medication you take for them. \_\_\_\_\_

Have you ever made a worker's compensation claim? If yes, how long ago? Please provide details. \_\_\_\_\_

Are you a smoker? \_\_\_\_\_

Do you have or have you ever had any of the following? Answer yes or no. If yes, please provide further detail in the comments section provided below.

Condition	Yes or No
Asthma, bronchitis, coughing, or any other respiratory conditions	
Eyes, nose, sinus or throat	
Heart disease, heart attack or blood pressure problems	
Infections such as Malaria, tuberculosis or typhoid	
Arthritis	
Bone or joint problems	
Any joint, muscle, tendon or ligament problems	
Any repetitive strain type injury	
Back complaint or back injury	
Any skin conditions	
Hepatitis or HIV	
Diabetes, thyroid or gland problems	
Epilepsy, fainting, fits blackouts or dizzy spells	
Vision problems that cannot be corrected by glasses	
Ear conditions including hearing loss, deafness or tinnitus	
Mental or psychiatric problems, depression	
Any prior vehicle or work related injury	

For any of the questions above that you have answered with yes, please provide details of the condition and current status.

Condition	Current status

Do you have any medical conditions that may impact upon your ability to safely carry out the tasks required in the position? If yes, please provide details. \_\_\_\_\_

**EMPLOYMENT HISTORY**

Employer	Position Held	Period Employed	Reason for leaving

Have you ever been required to supervise other employees? If yes, please provide details. \_\_\_\_\_  
 \_\_\_\_\_

Have you ever worked for Sealanes? If yes, what was the reason for leaving? Please provide details. \_\_\_\_\_

**REFERENCES**

Please specify details of persons who would be prepared to give a verbal reference.

Name	Title/Occupation	Telephone No:

**CONDITIONS OF EMPLOYMENT**

1. Prior to commencement of employment a current National Police Clearance must be provided at your own expense.
2. Prior to commencement of employment a full medical including drug and alcohol screening must be done with the cost covered by Sealanes. Please read Declaration Clause 7 for further conditions regarding the cost of the pre employment medical.

**DECLARATION – Any misrepresentation of facts in this application could be cause for termination if employed**

1. I declare that the information contained in this application is, to the best of my knowledge, true and correct at the time of completing this form.
2. I consent to any reference checks which may be necessary to support this application.
3. I agree, that should I be employed by Sealanes and my services be terminated for any reason, I will return any uniforms or protective clothing and equipment issued to me within the last three-month period. I also consent to the withholding of any outstanding wage payments due to me, until all such uniforms or protective clothing and equipment have been returned.
4. I agree that, should I become employed by Sealanes in a capacity that would require either driving a company vehicle or operating a company forklift, I will produce the original licence or certificate before driving or operating either of the said company equipment.
5. I am not currently receiving any payment and or treatment associated with an existing workers compensation claim.
6. I agree that pursuant to Section 79 of the Workers Compensation and Injury Management Act 1981, failure to disclose prior workers compensation claims may impact upon a decision being made in regard to future workers compensation claims.
7. If for any reason my employment is terminated or if I terminate my employment within one year of service, I understand that Sealanes will deduct the cost of the pre-employment medical from last pay payment.

**PRIVACY POLICY STATEMENT**

This application, along with any personal information collected by way of reference checks in relation to this application, shall be treated in the strictest confidence in accordance with National Privacy Principles (NPP's) and Sealanes Privacy Policy.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

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**OFFICE USE ONLY**

Date Commenced \_\_\_\_\_

Weekly Salary/Wage \_\_\_\_\_

Classification \_\_\_\_\_

Additional Income \_\_\_\_\_

Award \_\_\_\_\_

Allowances \_\_\_\_\_

New Position or Replacement \_\_\_\_\_

Hours \_\_\_\_\_

Department \_\_\_\_\_

Employee No \_\_\_\_\_

Authorised by

DIRECTOR	DIRECTOR	DEPARTMENT MANAGER
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