

10. Market Research

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| Indicate your current/ or last employment sector: | |
| Have you talked to a recruitment officer in regards to a career with UCH? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you seen UCH recruitment advertisements? If yes, where? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Local Newspaper <input type="checkbox"/> The West Australian <input type="checkbox"/> Seek.com <input type="checkbox"/> Word of mouth <input type="checkbox"/> Other _____ |
| Have you ever seen or attended a UCH career display/expo. If "yes" where? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Of the following areas, which one best describes why you are pursuing a role with UCH as a career? | <input type="checkbox"/> Aged Care <input type="checkbox"/> New Challenge <input type="checkbox"/> Job security <input type="checkbox"/> Diversity of work <input type="checkbox"/> Salary/conditions <input type="checkbox"/> Not for profit <input type="checkbox"/> Other Details: _____ |

11. Declaration

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| <p>I declare that the statements I have made and the information I have given are true to the best of my knowledge and belief. I have not withheld any relevant information required by this application, or made any false or misleading representation. I acknowledge that if I have knowingly or wilfully given false or misleading information or have withheld any information, it could result in 1) rejection of my application 2) legal proceedings against me; or 3) dismissal after appointment.</p> <p>I understand that appointment to UCH is conditional upon production of proof of identify, proof of residency status and a current satisfactory national police clearance.</p> <p>Signature: _____ Date: _____</p> <p><i>Thank you for taking the time to complete this application</i></p> |
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Pre-Employment Health Questionnaire

Please continue with the completion of this questionnaire. The general questions cover the physical demands involved in the full range of potential positions offered within Uniting Church Homes. The assessment serves as part of the comprehensive risk and recruitment strategies used by Uniting Church Homes to reduce risk to employees, co-workers, residents and clients, and is by no means a stand alone measure used to determine suitability for the position(s) applied for.

Applicant to complete all sections of this form (Please tick ✓)

Are you being treated by any doctor for any illness or injury (work related or otherwise), or required time off work recently? YES NO

If Yes Please Explain

Have you had any surgery or been hospitalised for any illness or injury (within last 5 years)? YES NO

If Yes Please Explain

Are you taking any medications for a medical condition? YES NO

If Yes Please Explain

Do you have a current Workers' Compensation claim? YES NO

If Yes Please Explain

Have you had a Workers' Compensation claim in the past or a work related injury or illness? YES NO

If Yes Please Explain including Date

Do you or have you ever had back, neck or shoulder problems? YES NO

If Yes Please Explain

Have you ever had an injury from a motor vehicle accident YES NO

If Yes Please Explain

Please tick (✓) in the box beside any condition/s that you have now or have had at any time in your life?

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|---|--|---|---|
| <input type="checkbox"/> Alcohol or Drug problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Bleeding/blood disorders |
| <input type="checkbox"/> Carpel tunnel syndrome | <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Immune suppression | <input type="checkbox"/> Joint problems/fractures |
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Psychological disorders | <input type="checkbox"/> Persistent Headaches/migraines | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Visual impairments | <input type="checkbox"/> Skin disorders/dermatitis | <input type="checkbox"/> Transmissible disease eg Hep B | <input type="checkbox"/> Repetitive strain/overuse injury |

Any other illness/conditions not listed on previous page:
Describe: _____

Please comment on all those you have ticked on previous page

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Please tick (✓) in the box beside each activity with which you have difficulty

- | | | |
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| <input type="checkbox"/> Walking 100 metres | <input type="checkbox"/> Standing for two hours | <input type="checkbox"/> Gripping firmly with both hands |
| <input type="checkbox"/> Hearing a normal conversation | <input type="checkbox"/> Crouching | <input type="checkbox"/> Climbing a ladder |
| <input type="checkbox"/> Lifting or bending | <input type="checkbox"/> Using hand tools | <input type="checkbox"/> Walking on rough ground |
| <input type="checkbox"/> Repetitive movement of the hands or arms | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Sitting for two hours |

Please comment on all those you have ticked above

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Have you had any exposure to the following in your past jobs

Loud noise/explosives/gunfire YES NO

If Yes Please Explain - When & where?

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Traumatic work event YES NO

If Yes Please Explain - When & where?

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Important Notice

Please note that under Section 79 of the Workers' Compensation and Rehabilitation Act, wilful and false representation regarding a previous disability may preclude the payment of future compensation.

Declaration For Medical Questionnaire

I declare that the answers to all questions are correct and that I have not withheld any information regarding my past or present health. I accept that if I am employed and it is subsequently found that I have wilfully misstated any significant information herein, I will be liable to dismissal.

I give my permission to the Employee Services Department or a medical practitioner nominated by the Uniting Church Homes to seek and obtain any other relevant information from any available source which may be required to assess my past and present health status.

Applicant's Signature

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Date

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Print Full Name: _____

NOTE: Completion of all sections must be confirmed prior to submission of your application form. Incomplete forms will not be considered for vacancies advertised or otherwise.