



APPLICATION FOR EMPLOYMENT
(PRIVATE AND CONFIDENTIAL)

Please return this form to:

Bradshaw Street
Heywood
Lancashire
England
OL10 1PL

Tel: 01706 360131/2 & 360551
Fax: 01706 625666 / 624518
www.gilwood.co.uk

(Please print information clearly.)

Position applied for:

Personal

Surname:	Forenames:
Address:	Telephone No:
	Married/Single/Divorced
	Number of children:
Post Code:	(Delete as applicable)

Are you of good health?	Yes / No
If no please give details:	
Are you registered disabled?	Yes / No
If yes please give details:	
Have you ever been convicted of a criminal offence:	Yes / No
Do you have a full/clean driving licence:	Yes / No

What salary would you expect?	
On what date would you be available to start work?	/ /
Have you previously worked for us?	Yes / No
If offered this position would you continue to work in any other capacity?	Yes / No

Education

School attended	From	To	Examinations/Results

College/University Attended	From	To	Courses and Results

Further Education	From	To	Courses and Results

Please outline the skills and experience you have gained through paid employment and other work activities and interests which are relevant to your application of this job:

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Employment History

List below present and past employment, beginning with your most recent

Name & Addresss of Employer	From	To	Describe the work you did May we contact this employer? Yes/ No
			Salary on leaving: £

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I give permission to contact the employers listed above concerning my prior work experience except those marked otherwise.

The inormation given in this Application Form is honest and correct

Signed: _____ Date: _____

IN CONFIDENCE

PRE-EMPLOYMENT HEALTH DECLARATION

TO SAFEGUARD THE HEALTH OF EMPLOYEES AND TO ENSURE THAT THEY ARE NOT EMPLOYED IN AREAS FOR WHICH THEY ARE MEDICALLY UNSUITED, IT IS NECESSARY FOR THIS DECLARATION TO BE COMPLETED.

<p><u>FIRST NAME(S):</u></p> <p><u>SURNAME:</u></p> <p><u>HOME TELEPHONE NUMBER:</u></p>	<p><u>HOME ADDRESS:</u></p>
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<p><u>FIRST NAME(S):</u></p> <p><u>FAMILY DOCTORS ADDRESS:</u></p> <p><u>FAMILY DOCTORS TELEPHONE NUMBER:</u></p>

PLEASE COMPLETE THE QUESTIONNAIRE OVERLEAF

PLEASE ANSWER THE QUESTIONS BELOW BY PLACING A TICK IN THE RELEVANT "YES" OR "NO" BOX. IF YOU ANSWER YES TO ANY QUESTION PLEASE GIVE DETAILS INCLUDING LENGTH OF ILLNESS AND APPROXIMATE DATES, WHERE RELEVANT, QUOTE ANY CURRENT MEDICATION

NAME:-

	QUESTION	YES	NO	DETAILS
1	Are you receiving treatment/ medication from a Doctor or attending a clinic, hospital or outpatient department?			
2	Are you about to do so?			
3	Have you ever been admitted to hospital for any reason?			
4	Have you a history of serious illness or disability, which frequently keeps you away from work?			
5	Have you been absent from work in the last 12 months for any medical reasons (for 1 week or more)			
6	Have you had an "x;ray" in the last 12 months?			
7	Have you had a blood test in the last 12 months?			
8	Have you ever been registered disabled or received a disability pension?			
9	Have you left a job or H.M forces on medical grounds?			
10	Do you wear glasses or contact lenses?			
11	Is your sight in each eye good enough for all usual activities even with glasses?			
12	Do you suffer from deafness or have a difficulty in hearing?			
13	Have you ever had problem or trouble with either ear?			
14	Have you had a medical examination in the last 12 months?			

	QUESTION	YES	NO	DETAILS
15	Heart trouble/attack, Angina?			
16	Sinusitis?			
17	Raised blood pressure?			
18	Bronchitis, Asthma, Pneumonia, Hayfever or any allergy?			
19	Severe shortness of breath?			
20	Rupture or Hernia Kidney or bladder disease?			
21	Diabetes?			
22	Fainting and or Giddiness?			
23	Blackouts, epilepsy or Fits?			
24	Recurring Headaches or Migraine?			
25	Mental illness, Depression, Nervous breakdown, or debility?			
26	Foot or knee trouble, back, Neck or spinal/disk disorders?			
27	Trouble Sciatica etc, Rheumatism / Arthritis?			
28	Serious accident?			
29	Skin disorders or Sensitivity etc?			
30	Disorders Affecting upper limbs?			
31	Do you have any other defect/ disorder or condition not mentioned above?			
32	Do you smoke?			How many?
33	Do you drink alcohol?			How many units?

CAREFULLY READ THE FOLLOWING DECLARATION AND SIGN BELOW:

I declare that to the best of my knowledge and belief, all the answers given in this declaration are correct, and understand that failure to disclose any medical information that may affect my employment could lead to the termination of employment.

I give my consent to the contents of this form being checked with my family doctor and agree that it required, a report may be obtained from my doctor or a specialist.

I understand that this form and any medical report will be treated in confidence but the management may use advice based upon it.

Signed..... Date.....