



**STRICTLY PRIVATE + CONFIDENTIAL APPLICATION FOR  
EMPLOYMENT**

POSITION APPLIED FOR: \_\_\_\_\_

**PERSONAL DETAILS**

FORENAMES: \_\_\_\_\_

SURNAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_

DEPENDANTS: \_\_\_\_\_

NATIONALITY: \_\_\_\_\_

If a non-EC National, do you hold a current UK Work Permit: YES / NO

**NEXT OF KIN**

NAME: \_\_\_\_\_

TELEPHONE No: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

*Do you have any relatives working at this Company?* **YES/NO**  
*Are you a member of a Trade Union?* **YES/NO**  
*Would you be prepared to work a shift system?* **YES/NO**

**EDUCATION AND TRAINING**

<b><u>FROM</u></b>	<b><u>TO</u></b>	<b><u>PLACE OF SECONDARY EDUCATION (SCHOOL/COLLEGE)</u></b>	<b><u>SUBJECT</u></b>	<b><u>QUALIFICATIONS ACHIEVED (GCSE /A -LEVEL/ETC)</u></b>

**EMPLOYMENT HISTORY**

*Starting with most recent position and working back in chronological order*

<u>COMPANY</u>	<u>POSITION HELD</u>	<u>DATES</u>		<u>MAIN RESPONSIBILITIES</u>	<u>SALARY</u>	
		<u>FROM</u>	<u>TO</u>		<u>STARTING</u>	<u>FINISHING</u>

**HEALTH**

Are you a registered disabled person? YES/NO

If yes, registered number: \_\_\_\_\_

**Do you suffer from or have you ever suffered from any of the following:-**

- |   |        |
|---|--------|
| 1. Epilepsy?  | Yes/No |
| 2. Diabetes?  | Yes/No |
| 3. Fits, dizziness, giddiness or blackouts?   | Yes/No |
| 4. Any mental illness?  | Yes/No |
| 5. Vertigo or ear problems  | Yes/No |
| 6. Recurring eye problems   | Yes/No |
| 7. Any form of deafness or ear disorder   | Yes/No |
| 8. Any recurring stomach problems   | Yes/No |
| 9. Any allergies  | Yes/No |
| 10. Asthma, breathing difficulties, recurring chest infections, nose or throat disorder                                     | Yes/No |
| 11. Back problems, hernias or disc injuries   | Yes/No |
| 12. Problems with your lower limbs  | Yes/No |
| 13. Any problems relating to repetitive work, e.g. tendonitis, tinosynovitis, carpal tunnel syndrome, tennis elbow, RSI etc | Yes/No |
| 14. Any symptoms of hand arm vibration or Raynaud's disease   | Yes/No |
| 15. Dermatitis or skin disorders  | Yes/No |
| 16. Recurring headaches or eye strain   | Yes/No |
| 17. Any form of motor function disease  | Yes/No |
| 18. Blood disorders   | Yes/No |
| 19. Heart or other circulatory problems   | Yes/No |
| 20. Arthritis or rheumatism   | Yes/No |
| 21. Colour blindness  | Yes/No |
| 22. Any industrial injury or disease/made a claim for same?   | Yes/No |
| 23. Any condition or illness that could be aggravated by night work?  | Yes/No |

**Have you previously been in contact with or worked with:**

- |  |        |
|--|--------|
| 24. Noisy machinery                          | Yes/No |
| 25. Asbestos                                 | Yes/No |
| 26. Lead                                     | Yes/No |
| 27. Are you currently taking any medication? | Yes/No |
| 28. Do you smoke?                            | Yes/No |

---

Please provide additional details to any questions answered with a Yes in the box below. You should also provide any additional information that you feel might be relevant.

---

Under the Disability Discrimination Act the company is obliged to make reasonable adjustments or adaptations that may be necessary. Are you aware of any adjustments that may be required to assist you if you are offered employment in the workplace? If yes, please detail under:

---

Have you a full clean driving licence?

YES/NO

---

Have you had any previous criminal convictions?  
(If so please give details)

YES/NO

---

SPARE TIME ACTIVITIES/HOBBIES

---

ANY FURTHER INFORMATION THAT YOU FEEL MAY BE OF INTEREST

---

PERSONAL REFERENCES

---

I declare that the foregoing information is true and correct and that I have disclosed to the best of my knowledge any condition, which may affect my work and have not withheld any material fact. I confirm that if I have any future health problems that I will immediately notify the company. I give my ***express permission*** for the information contained in this form to be disclosed to a designated medical practitioner.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_