



Employment Application Form

Please take the time to complete all sections of this application form, including answering all questions and dating and signing where requested.

1. Personal Details

Name: _____

Address: _____

Contact Telephone Number: _____ Mobile _____

Email address: _____

2. Position Applying For: _____

Preferred status (full time/part time/casual/etc): _____

3. Education and Training

Name of school, university etc	Educational level or qualification	Date completed

4. Employment History

Have you ever worked for Kingston Estate Wines? Yes No

If yes, please specify _____

Previous Employment - Please list your last 3 employment situations (most recent employer first)

Employer 1

Name: _____

Address: _____

Job Title: _____



Duties/ Responsibilities: _____

Period of Employment: From _____ to _____

Reason for leaving: _____

Employer 2

Name: _____

Address: _____

Job Title: _____

Duties/ Responsibilities: _____

Period of Employment: From _____ to _____

Reason for leaving: _____

Employer 3

Name: _____

Address: _____

Job Title: _____

Duties/ Responsibilities: _____

Period of Employment: From _____ to _____

Reason for leaving: _____

4a. Referees

Please list 3 past and present employers. Referees should include a recent direct Supervisor/Manager.

Referee Name	Company	Position	Current Phone

5. General information

If you are a non-resident of Australia, are you eligible to work in Australia?

Yes (if yes please attach proof of eligibility) No



Do you suffer allergic reactions to:

- | | | | | |
|------------------------------------|--------------------------|-----|--------------------------|----|
| Sulphur dioxide (SO2) | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Milk Powder | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Enzyme powders and preparations | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Egg Whites | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Other, if yes please specify below | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

Have you had any previous injuries or serious illnesses (including workplace injuries)?

- Yes No

If yes, please specify _____

Do you have any disability or condition (medical or otherwise) which may affect your work performance?

- Yes No

If yes, please specify _____

Are you on any prescribed medication that may affect your ability to operate equipment?

- Yes No

If yes, please specify _____

Are there any other reasons that may affect your ability to perform the required duties?

- Yes No

If yes, please specify _____

Would you undergo a medical examination? Yes No

Given appropriate notice, would you be able to work outside of normal hours? Yes No

Complete for Production/Winery based applications only

Are you prepared to work weekends? Yes No

Are you prepared to work alternate shifts? Yes No



6. Licences and Certificates - Complete for Production/Winery based applications only

Do you have a current driver's licence? Yes No

Do you have a means of transport? Yes No

Do you have a forklift driver's licence? Yes No

Do you have an elevated platform work licence? Yes No

Do you have a truck driver's licence? Yes No

If yes, please state what type: _____

Have you received Confined Space Entry training? Yes No

If yes, please state when: _____

Do you have a current Senior First Aid certificate? Yes No

7. Additional Information

Please add or attach any additional relevant employment information you wish to be considered in support of your application.

8. Declaration by Applicant

I declare that

- a) The answers to the foregoing are to the best of my knowledge and are true and correct in every way.
- b) If my application for employment is successful, I will be bound by, observe and respect all terms and conditions of my employment and policies and rules as may from time to time be promulgated, specified or otherwise stipulated by my employer.
- c) I understand that any erroneous or false declaration made by me in this application may result in disciplinary action, or possible dismissal.
- d) I understand that if my application is successful, my employment may be subject to a satisfactory medical report provided by a Medical Practitioner nominated by the employer.

Signed: _____ Date: _____



Medical Assessment

Name: _____

Date: _____

CONFIDENTIAL

NOTICE REGARDING MEDICAL INFORMATION

Employers have a duty of care to ensure prospective employees are fit to safely perform the duties of the position. It is also to the advantage of potential employees that they can be placed in an appropriate position related to their individual circumstance. The aim of this pre-placement assessment is ensure the applicant is fit to undertake the intended role and the alterations to the role, if any, which may be necessary to minimise risk of injury or illness in the workplace. Pre-employment medical assessments are necessary to determine that:

- *The applicant is able to carry out the duties of the position safely*
- *The applicant does not, because of a medical condition, increase risk to other workers, equipment, products or the general public.*
- *The worker is not going to be placed at significant risk of exacerbating existing medical conditions.*

To assist your potential employer in assessing your fitness for the position, you must answer the questions contained in this questionnaire truthfully and to the best of your knowledge. The information you provide will be treated as confidential but will be released to your potential employer for their purposes in assessing your fitness for employment.

Please note: Failure to disclose any relevant matter relating to your health or false declarations may result in your employment being terminated.

Confidential Employee Medical Record

PART A: Medical History

Instruction to Applicants:

Part A is to be completed by the applicant/employee and may be reviewed by a Medical Practitioner. The information sought in this health assessment remains strictly confidential.

Your appointment may be subject to a Medical Assessment by a medical practitioner and a blood test.

Do you consent? **Yes / No** (please circle) _____ (please sign)

Present and Past Medical History:

(Please circle answer and provide details where necessary)

Have you had an allergic reaction to:		
Sulphur dioxide (SO ₂)	Yes	No
Milk powder	Yes	No
Enzyme powders and preparations	Yes	No
Egg whites	Yes	No
Other, if yes please state:	Yes	No
Have you had a tetanus vaccination?	Yes	No
Date of last vaccination:		
Have you had any other recent vaccinations?	Yes	No
Date and type of vaccination:		
Date and type of vaccination:		
Are you currently being treated by any doctor for any illness?	Yes	No
Details:		
Are you currently taking any medication including inhalers?	Yes	No
Details:		
Have you ever suffered from back, neck or spinal problems including whiplash?	Yes	No
Details:		
Have you ever suffered any major illness or injury requiring medical attention or hospitalisation?	Yes	No
Details:		
Have you ever had a disease or injury resulting from work?	Yes	No
Details:		
Do you consume alcohol?	Yes	No
How much per day:		
Do you smoke or use recreational drugs/ substances?	Yes	No
Details:		
Do you have a fear of heights?	Yes	No
Are you able to walk up stairs without difficulty?	Yes	No
Do you have difficulties lifting heavy weights?	Yes	No



Do you suffer or have you suffered from RSI, tennis elbow or tenosynovitis?	Yes	No
Have you broken or fractured any bones?	Yes	No
Have you visited a physiotherapist or chiropractor?	Yes	No
Have you ever had an x-ray or scan of your back or neck?	Yes	No
Have you ever had an operation?	Yes	No
Do you have trouble wearing protective equipment? (ear plugs/ footwear etc)	Yes	No
Are you able to crouch without difficulty?	Yes	No
Can you bend repeatedly?	Yes	No
Do you have difficulty sitting for extended periods of time?	Yes	No
Can you kneel, squat, crouch and stand up easily?	Yes	No
Do you have difficulties standing for long periods of time?	Yes	No
Can you perform repetitive movements of your arms?	Yes	No
Are you able to work comfortably in confined spaces?	Yes	No
Do you have any problems working above shoulder height?	Yes	No

Additional Information:

Have you ever had any of the following:

(Please circle answer)

Condition	Yes	No	Doctors' Comments
Tuberculosis	Yes	No	
Rheumatic fever	Yes	No	
Epilepsy/ fits	Yes	No	
Stomach or duodenal ulcers	Yes	No	
Passing or vomiting blood	Yes	No	
Diabetes	Yes	No	
Dermatitis/ eczema/ psoriasis	Yes	No	
Recent weight loss or gain	Yes	No	
Cancer or tumour of any kind	Yes	No	
Any congenital condition	Yes	No	
Arthritis	Yes	No	
Back pain, back injury, sciatica	Yes	No	
Hernia	Yes	No	
Head injury, concussion	Yes	No	
Foot trouble	Yes	No	
Other joint injuries or conditions	Yes	No	
Ankle or knee trouble	Yes	No	
Bruising or excessive bleeding	Yes	No	
Injury requiring an operation	Yes	No	
Heart trouble, angina, chest pain	Yes	No	



Palpitations, irregular heart beats	Yes	No	
Shortness of breath	Yes	No	
High blood pressure	Yes	No	
Eye trouble	Yes	No	
Earache or discharge from ears	Yes	No	
Hearing loss/ defect	Yes	No	
Had > 5 days of sick leave in a year	Yes	No	
Hay fever	Yes	No	
Wheezing/ asthma	Yes	No	
Depression	Yes	No	
Anxiety/ stress	Yes	No	
Other mental illness	Yes	No	
Blackouts/ fainting	Yes	No	
Frequent or migraine headaches	Yes	No	
Seen a psychologist or psychiatrist	Yes	No	

Have you ever had a work injury claim and if so, please advise date and include details:

Occupational Exposure:

Give details of previous work exposure to the following:

Dust: _____

Noise: _____

Chemicals: _____

Repetitious Work: _____

Are there any reasons you may have difficulty in carrying out the day-to-day tasks of this position?



Declaration by Applicant

APPLICANT'S DECLARATION

I hereby declare that:

- I have read and understood the conditions on this form
- My answers are true and complete to the best of my knowledge
- I understand that, if employed, the information I provide will be retained by my employer for its purposes

I understand that if I fail to disclose any relevant matter relating to my health, which renders me incapable of properly and safely fulfilling the duties of the position, it may affect my conditions of employment including disciplinary action or dismissal.

I consent to the medical representative to obtain or exchange further medical information from my treating doctor(s) or health practitioner(s), if required for the purposes of this assessment

Name of applicant (Print)

Signature of applicant

Date