COMPLETE STAFF SOLUTIONS
right people, right job, right time

General Registration Form

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Full Name: Date of Birth:

Address:

Suburb:

Phone: Mobile:

Email:

Do you identify as being of Aboriginal or Torres Strait Islander descent? ☐ Yes ☐ No

What type of work are you seeking?

☐ Process Work ☐ Cleaning ☐ Administration ☐ Labouring

☐ Forklift Driving ☐ Store Person ☐ Trades ☐ Truck Driving

☐ Traffic Control ☐ Customer Service ☐ Plant Operation ☐ IT

Other:

Do you have a current Drivers Licence? ☐ Yes ☐ No Class:

Do you have your own Transport? ☐ Yes ☐ No

If No, How will you get to work?

Preferred Work Locations?

Are you available for casual and temporary work? ☐ Yes ☐ No

How much work are you ideally seeking? ☐ Full time ☐ Part time ☐ Casual ☐ Any

What days and times are you available for work?

Monday:	☐ Morning	☐ Afternoon	☐ Night
Tuesday:	☐ Morning	☐ Afternoon	☐ Night
Wednesday:	☐ Morning	☐ Afternoon	☐ Night
Thursday:	☐ Morning	☐ Afternoon	☐ Night
Friday:	☐ Morning	☐ Afternoon	☐ Night
Saturday:	☐ Morning	☐ Afternoon	☐ Night
Sunday:	☐ Morning	☐ Afternoon	☐ Night

Do you have any planned holidays or dates that you will not be available for work in the foreseeable future? ☐ Yes ☐ No

Reason:

Date/s unavailable?

Are you currently working? ☐ Yes ☐ No

If yes; who is your current employer and what is your current position?

What notice are you required to giver employer?

Why are you seeking other work?

If no; why did you leave your last position?

Do you have Steel Cap Boots ☐ Yes ☐ No

Please list below any licences/tickets or qualifications you hold and or computer systems/qualifications you have e.g. White Card, Traffic Control, Trim, MYOB etc (*Copies may be requested)*

Have you ever been injured at work? ☐ Yes ☐ No

If Yes, please give details;

Please indicate your citizenship or "right to work status" *(a copy of your VISA or passport may be required)*

☐ Australian Citizen (Permanent Resident) ☐ Working Visa

☐ Student Visa ☐ Other

Visa Type: Visa Number:

Are you registered as a job seeker? ☐ Yes ☐ No

If Yes; What is your Job Seeker ID Number?

Which Job Services agency are you registered with?

I hereby declare that the information given by me on this form is, to the best of my knowledge, true and complete. I am, to the best of my knowledge, able to perform the duties of the position(s) I have applied for. I hereby give consent for information provided by me, including resume, CV etc. to be disclosed to prospective employer(s) or host(s) for the purpose of assisting my appropriate placement in the workplace and to ensure the protection of the health and safety of others in the work environment.

Full Name:

Signature: **Date:**

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EMPLOYEE HEALTH QUESTIONNAIRE

Please answer ALL questions. If you have difficulty answering any question/s, please do not hesitate to ask your consultant for assistance. After you have completed the questionnaire, please sign where indicated and hand back to your consultant.

Completion of this form is not an offer of employment. Your answers to the questions below are important in enabling Complete Staff Solutions to place you in work that, as far as is practicable, does not place you at risk of injury and to identify actions that may be required to make the job safer for you.

If you give any information that you know to be false – or if you withhold any information – your application may be rejected – or if already appointed, you may be dismissed.

Full Name:

Date of Birth: / / Height: Weight:

Your Nominated Emergency Contact

Emergency Contact Name:	Relationship to you:
Address:	
	Postcode:
Mobile Phone:	Work Phone:
Home Phone:	

GENERAL HEALTH

Have you EVER had or are you suffering from any of the following? *Please circle the specific aliment if you intend to select "Yes"*

Do you have the need to carry an EpiPen?	Yes No
Skin rashes, eczema or dermatitis	Yes No
Allergies (Hay fever, drugs, animals) *If "Yes" name the source of the irritation;*	Yes No
Frequent colds, sore throats, sinus, hay fever?	Yes No
Kidney or bladder trouble?	Yes No
Sudden attacks of giddiness, fainting or blackouts?	Yes No
Indigestion, heartburn, ulcers?	Yes No
Difficulty with fine motor movements, E.g. Setting your watch, tying shoelaces?	Yes No
Have you ever failed a medical test?	Yes No
Have you ever consulted, or been recommended to consult a medical specialist?	Yes No
Have you ever been hospitalized as a patient?	Yes No
Do you have an existing injury or condition or a pre-existing injury or condition? *If "yes", please provide details;*	Yes No
Have you ever worked with any substance or in any conditions which may have been hazardous to your health (e.g. Asbestos exposure, toxic chemicals, stressful or noisy environments) & for which you need a modified workplace?	Yes No

GENERAL HEALTH CONTINUED

Have you EVER had or are you suffering from any of the following? *Please circle the specific aliment if you intend to select "Yes"*

Have you been advised for medical reasons not to do night work, shift work or any other kind of work?	Yes No
Have you ever undergone health surveillance due to hazards in your previous job?	Yes No
Are you in receipt of a disability pension?	Yes No
Have you ever been medically retired from a previous position?	Yes No
Do you smoke (cigarettes/cigars/pipes etc.)?	Yes No
If "yes", how many per day?	
Do you drink alcohol?	Yes No
If "yes", what is your average weekly intake?	
Within the past 12 months how many days have you been unable to attend work/studies or undertake daily living tasks through sickness?	
How many episodes of sickness absence have you had?	

MEDICAL HISTORY

Have you EVER had or are you suffering from any of the following? *Please circle the specific aliment if you intend to select "Yes"*

Bronchitis, pneumonia, pleurisy, tuberculosis, chronic cough, or any other lung disease - shortness of breath, Asthma?	Yes No
Heart condition, chest pains, rheumatic fever, anaemia, Blood pressure: High Low	Yes No
If Yes; is the above condition corrected by medication?	Yes No
X-ray of chest? Date:	
Difficulties with vision that is not corrected by prescription glasses. E.g. Blurred vision, glare, dazed by lights, or do you have any eye disease or eye problems?	Yes No
Do you wear glasses or contact lenses? When was your last eyesight test? Year:	Yes No
Difficulty in differentiating between colours, especially red, blue, green and yellow?	Yes No
Ringing in the ears, deafness, perforation, discharge, operations, or any other ear injury?	Yes No
Does your hearing prevent you from performing any tasks?	Yes No
Nose obstruction, bleeding, polyps, infection?	Yes No
Epilepsy?	Yes No
Persistent headaches/migraines?	Yes No
Varicose veins, haemorrhoids?	Yes No
Sleep apnoea, narcolepsy or cataplexy?	Yes No
Nervous disorder, breakdown, severe depression, anxiety, psychiatric disorder, Alcohol /Substance abuse?	Yes No
If "Yes", is the above corrected by medication?	Yes No
Diabetes?	Yes No
Thyroid, other glandular disorder?	Yes No
If Yes; is the above condition corrected by medication?	Yes No
Rupture, hernia or intestinal complaint?	Yes No

MEDICAL HISTORY CONTINUED

Have you EVER had or are you suffering from any of the following? *Please circle the specific aliment if you intend to select "Yes"*

Bleeding or blood disorders?	Yes No
Cancer, tumour or other malignancy?	Yes No
Disease of the kidney, liver, gall bladder, pancreas?	Yes No
Infectious disease? E.g. Hepatitis, TB (Tuberculosis), glandular fever, Q Fever	Yes No
Bone/joint problems such as arthritis, rheumatism, sciatica, fibrositis, gout or limited range of movement of any joint?	Yes No
Recurring back or neck pain problems – spinal, disc disorder or repetitive strain injury?	Yes No
Shoulder, elbow, wrist, knee, ankle, chest/rib, hip, leg trouble or injury? *(Please Circle)*	Yes No
Recurring problems with broken bones? Please list;	Yes No
Any serious injury or illness? *Details;*	Yes No
Do you have *any* condition (physical or mental) that could impact on your work & safety or that of others?	Yes No
Are you currently on any medication or treatment including counselling, prescribed by a doctor? Please list;	Yes No
Have you ever been injured at work? *Details;*	Yes No
Did this involve a "Return to Work Plan"?	Yes No

Do you have any problems with the following activities?

Repetitive bending?	Yes No	Climbing ladders?	Yes No
Repetitive lifting?	Yes No	Standing for long periods?	Yes No
Repetitive hand/arm movements?	Yes No	Sitting for long periods?	Yes No
Working in hot environments?	Yes No	Crouching?	Yes No
Working in cold environments?	Yes No	Kneeling?	Yes No
Working at heights?	Yes No	Walking on uneven ground?	Yes No

Have you had vaccinations for;

Tetanus?	Unsure	Yes	No
Hepatitis A?	Unsure	Yes	No
Hepatitis B?	Unsure	Yes	No
TB (Tuberculosis)?	Unsure	Yes	No
COVID19 Vaccination ?	Yes, Shot 1	Yes, Shot 2	No
Do you object to a breathalyzer test for alcohol or urine test for other drugs?		Yes	No

I consent to my treating medical practitioner, my employer, the insurer, other medical practitioners or health related practitioners (whether consulting, treating or examining), workplace rehabilitation providers and regulatory authority exchanging information for the purpose of managing my injury and workers compensation claim with Complete Staff Solutions or their representative. I understand this information will be used by the regulatory authority, Complete Staff Solutions and the insurers to fulfill their functions under the workers' compensation legislation.

This applies to any injury that I may sustain in the course of my employment with Complete Staff Solutions. If a workplace injury is sustained whilst working for Complete Staff Solutions, I agree to allow the Complete Staff Solutions Representative to attend all medical appointments related to this injury.

Signature: Date:

*****Please complete either the "Declaration" or "Statutory Declaration" field as applicable below*****

DECLARATION

I understand the requests that have been made upon me to provide as much relevant information as I can. Furthermore, I declare that to the best of my knowledge the answers I have provided in this questionnaire are correct and I understand that if false or deliberately misleading information is given, or any material fact suppressed, I will not be considered for employment, or if I am employed, my employment will be terminated.

Signature: Date:

OR

STATUTORY DECLARATION - *OATHS ACT 1900*, NSW, EIGHTH SCHEDULE

I, ..., do solemnly and sincerely declare that
[name of declarant]

I have truthfully completed the Complete Staff Solutions Health Questionnaire and I make this solemn declaration conscientiously believing the same to be true, and by virtue of the provisions of the *Oaths Act 1900*.

Declared at: ..... on..... Signature.....
[place] *[date]* *[signature of declarant]*

in the presence of an authorised witness, who states:

I, ..., a .....,
[name of authorised witness] *[qualification of authorised witness]*

certify the following matters concerning the making of this statutory declaration by the person who made it: *[* please cross out any text that does not apply]*

1. *I saw the face of the person *OR* *I did not see the face of the person because the person was wearing a face covering, but I am satisfied that the person had a special justification[1] for not removing the covering, and
2. *I have known the person for at least 12 months *OR* *I have confirmed the person's identity using an identification document and the document I relied on was
   .....
   [*describe identification document relied on]*

.....
[signature of authorised witness] *[date]*

[1] The only "special justification" for not removing a face covering is a legitimate medical reason (at September 2018)

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DRUG DECLARATION AND DISCLOSURE

At Complete Staff Solutions, we have a zero tolerance attitude towards illegal drugs and the potential impairment of workers.

As part of this commitment, our recruitment practices may include pre-employment drug testing and possible random drug testing. This commitment is supported by our Drug and Alcohol policy.

By signing this disclosure, you are confirming that:

- You would successfully pass a drug screen
- You have not used any illegal drugs including marijuana within the last 12 weeks

We are committed to ensuring we provide our clients with candidates who are safe, productive and not impaired by any illicit drugs.

The below declaration is an essential requirement of our recruitment practices. Should you be unable to sign the declaration we will be unable to proceed with your application at this time. Should you wish to be considered at another time when able to sign this declaration, we shall accept another application.

Acknowledgement:

(please tick)

1. I will pass a drug screening test (I have not taken any illegal drugs, including marijuana within the last 12 weeks) ☐

OR

2. I will NOT be able to proceed ☐

I have read and understood the Complete Staff Solutions document as above;

Full Name:

Signature: **Date:** / /

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REFERENCE CHECK & PRIVACY AUTHORISATION

WORK RELATED REFERENCES ONLY

Acknowledgement

I, PLEASE PRINT NAME

hereby nominate the individuals listed below to act as referees on my behalf and give authorisation to Complete Staff Solutions to contact these individuals.

I also give permission to Complete Staff Solutions to pass on to its Clients' information obtained from my referees, documentation, interviews and by observation of me that is relevant to the pre-requisites of any position registered with Complete Staff Solutions for which I may apply or be considered suitable.

I have, or will, notify the nominated individuals that they may be contacted by Complete Staff Solutions to obtain reference information.

Signature: **Date:**

Referee's Details:

1. Name:

Position:

Company:

Address:

Postcode:

Phone Numbers: Email:

2. Name:

Position:

Company:

Address:

Postcode:

Phone Numbers: Email:

3. Name:

Position:

Company:

Address:

Postcode:

Phone Numbers: Email: