THE CASINO FOOD CO-OP SINCE 1933	**Northern Co-operative Meat Company Ltd** **Supporting Equal Opportunity and Gender Diversity.**	**Date Received**

EMPLOYMENT APPLICATION FORM

IMPORTANT, PLEASE READ THE FOLLOWING NOTES BEFORE COMPLETING THIS APPLICATION FORM:

- **Completion of this form is not an offer of employment,** it is an application for employment listing certain details of your employment experience/qualifications for consideration.
- This application is confidential and **should be completed personally** by the applicant.
- Please mark your answers with 'x" in the □ to indicate "Yes or No" questions.
- **All questions must be answered** for your application to be considered.
- Applications and enquiries can be directed to: **hr@cassino.com.au**

PLEASE PROVIDE COPY OF PHOTO IDENTITY

Position Applied for:		
Application Date:		
Casino Plant ☐	Casino Hide Tannery ☐	Booyong Plant ☐

1.1 PERSONAL DETAILS			
Preferred Title:		**Date of Birth:**	
Surname:		**Given Names:**	
Address:			
Town:		**Post Code:**	
Telephone: (H)		**Mobile:**	
Email:			

1.2 EMERGENCY CONTACT DETAILS					
Surname:		**Given Names:**			
Address:					
Town:		**Post Code:**			
Telephone: (H)		**Work:**		**Mobile:**	
Relationship to you:					

1.3 CITIZENSHIP DETAILS		
Are you an Australian citizen?		**Yes ☐ No ☐**
If yes, can you produce evidence if required?		**Yes ☐ No ☐**
Aboriginal or Torres Strait Islander origin?		**Yes ☐ No ☐**
Other nationality?		
And, are you entitled to work in Australia		**Yes ☐ No ☐**
If yes, can you produce evidence of this?		**Yes ☐ No ☐**

2 EDUCATION AND COMPETENCIES	
2.1 Licences Held	**Expiry Date**
2.2 School (Show year/grade completed)	**Date Completed**
2.3 Trade or Tertiary Qualifications	**Date Completed**

3 EMPLOYMENT HISTORY			
3.1 Prior Employment with the Northern Cooperative Meat Company			
Have you ever worked for the Northern Cooperative Meat Company before? If Yes, which department and which year and the reason for your termination			**Yes ☐ No ☐**
Department:		**Year:**	
Reason for Termination:			

3.2 Current or Most Recent Employer			
Employer Name:			
Employed From:		**Employed To:**	
Address:			
Location:		**Phone:**	
Positions Held:			
Reason for leaving:			

3.3 Previous Employer			
Employer Name:			
Employed From:		**Employed To:**	
Address:			
Location:		**Phone:**	
Positions Held:			
Reason for leaving:			

3.4 Previous Employer			
Employer Name:			
Employed From:		**Employed To:**	
Address:			
Location:		**Phone:**	
Positions Held:			
Reason for leaving:			

4 SECONDARY EMPLOYMENT	
4.1 Do you have any secondary employment?	**Yes** ☐ **No** ☐
4.2 If so, please provide details	

5 REFEREES		
Provide details of three CONTACTABLE referees (not relatives)		
Name & Company	**Position**	**Telephone**

6 GENERAL	
6.1 Are you prepared to work shifts, if requested to do so?	**Yes** ☐ **No** ☐
Comment:	
6.2 Are you prepared to work overtime if required?	**Yes** ☐ **No** ☐
Comment:	
6.3 Are you prepared to abide by all Safety and Hygiene Rules?	**Yes** ☐ **No** ☐
Comment:	
6.4 Do you have any health problems or medical condition that may affect your ability to perform the requirements of this position?	**Yes** ☐ **No** ☐
Please detail if yes:	
6.5 Have you had any major illnesses or accidents in the last 5 years?	**Yes** ☐ **No** ☐
Please detail if yes:	
6.6 Have you ever claimed Workers' Compensation for any reason?	**Yes** ☐ **No** ☐
Please detail if yes:	
6.7 Is there any additional information which you would like to include to support your application for employment?	**Yes** ☐ **No** ☐
Please detail if yes:	

7 HEALTH QUESTIONNAIRE			
Full Name:		**Date of Birth**	
Height (cm)		**Weight (kg)**	

Please answer by circling all of the following questions

Asthma / Bronchitis	**Yes ☐ / No ☐**	Diabetes	**Yes ☐ / No ☐**
Asbestosis / Silicosis	**Yes ☐ / No ☐**	Epilepsy	**Yes ☐ / No ☐**
Shortness of breath	**Yes ☐ / No ☐**	Strokes	**Yes ☐ / No ☐**
Sinusitis	**Yes ☐ / No ☐**	Cardiac (heart) problems	**Yes ☐ / No ☐**
Pneumonia	**Yes ☐ / No ☐**		
Pneumothorax	**Yes ☐ / No ☐**	Alcohol / drug abuse	**Yes ☐ / No ☐**
		Mental illness	**Yes ☐ / No ☐**
Tenosynovitis / carpal tunnel syndrome	**Yes ☐ / No ☐**	Cancer --- (Type)	**Yes ☐ / No ☐**
Repetitive strain injuries	**Yes ☐ / No ☐**	Vertigo	**Yes ☐ / No ☐**
Arthritic joints	**Yes ☐ / No ☐**	Fainting / Giddiness	**Yes ☐ / No ☐**
Back problems	**Yes ☐ / No ☐**	High / Low Blood Pressure	**Yes ☐ / No ☐**
Neck / spine problems	**Yes ☐ / No ☐**	Migraine headaches	**Yes ☐ / No ☐**
Wrist / elbow/ arm problem	**Yes ☐ / No ☐**	Hearing loss	**Yes ☐ / No ☐**
Ankle / knee / leg problems	**Yes ☐ / No ☐**	Vision defects	**Yes ☐ / No ☐**
Any major sprains/ strains	**Yes ☐ / No ☐**		
Ganglion	**Yes ☐ / No ☐**	Other (please specify)	**Yes ☐ / No ☐**
Hernia-inguinal / abdominal	**Yes ☐ / No ☐**		
Gastroenteritis	**Yes ☐ / No ☐**	Please write, in detail, anything you know that may affect the way you are able to perform in the prospective employment position.	
Indigestion / dyspepsia	**Yes ☐ / No ☐**		
Stomach ulcer	**Yes ☐ / No ☐**		
	Yes ☐ / No ☐		
Q-fever / leptospirosis	**Yes ☐ / No ☐**		
Tuberculosis / Brucellosis	**Yes ☐ / No ☐**		
Warts	**Yes ☐ / No ☐**		
Dermatitis	**Yes ☐ / No ☐**		
Acne	**Yes ☐ / No ☐**		

Q FEVER INFORMATION & CONSENT

Q-Fever is an infection that can result from contact with the body fluids of infected animals. Q-Fever infection normally occurs by inhalation of infected aerosols (dust or small particles in the air). The symptoms of Q-Fever are similar to the “flu”. Symptoms may include any of the following, fever, chills, cough, muscle pains and severe headache. The illness lasts usually about seven (7) to fourteen (14) days.

Some patients suffer a pneumonia-like illness, a liver infection or occasionally an infection in the valves of the heart. Death from Q-Fever is very rare but may occur in the elderly and the sick. People working in abattoirs have the highest risk of contracting Q-Fever. After recovery, most people are immune and will not suffer symptoms of the infection again.

If you believe that you have previously been vaccinated against Q-Fever, NCMC requires you to supply evidence of this.

If you have not had Q-Fever or are unsure, you will need to have a blood and skin test. These tests are necessary before vaccination, to reduce the risks concerned with double vaccination. If both the skin and blood tests are negative, then you will be required to undergo vaccination. Like all vaccines, you may get a reaction to the vaccine. This is usually tenderness and redness to the vaccination site. You may get a headache or have some flu-like symptoms.

Please note: There is no information on the use of Q-VAX(R) in pregnancy. It is recommended that vaccination is deferred.

Before the vaccine, please answer the following questions:

1. Have you read and understood the above information? YES ☐ NO ☐
2. Are you allergic to eggs? YES ☐ NO ☐
3. Have you any chronic illness? YES ☐ NO ☐
4. Have you previously been vaccinated for Q Fever? YES ☐ NO ☐
5. Have you had Q fever before? YES ☐ NO ☐
6. **Female applicants**: are you pregnant or have reason to believe you may be? YES ☐ NO ☐

I _____ consent to undergoing:

a) Blood test and skin test
b) Q Fever vaccination

Print Name	Signature	Date

Q FEVER PARENT/GUARDIAN CONSENT

Persons under the age of 18 are required to provide parental consent for the vaccination. The company will provide vaccination upon parent or guardian consent.

Parent/Guardian consent: I consent for _____,

aged_____ to participate in a Q-Fever pre-screening process and subsequent

Q-Fever vaccination if required YES ☐ NO ☐

Parent/Guardian Name	Parent/Guardian Signature	Date

8. DECLARATION

DO NOT SIGN THIS DECLARATION UNLESS YOU CLEARLY UNDERSTAND IT. IF IN DOUBT, PLEASE CONTACT OUR HUMAN RESOURCES OFFICE ON (02) 66 600 838

PLEASE ENSURE YOU HAVE ANSWERED ALL QUESTIONS.

I declare that to the best of my knowledge the answers in this Application are correct and I understand that if any 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 immediately terminated. By signing below, I consent to the collection of the above personal information including my health and medical information.

Applicant

Name	**Signature**	**Date**

Witness

Name	**Signature**	**Date**