



**ROCKY BAY**  
*Discovering Abilities*

# Application for Employment

60 McCabe Street, Mosman Park, WA, 6012  
Tel: 9383 5129 Fax: 9383 1230

ADDRESS ALL CORRESPONDENCE TO:  
Recruitment Team, PO Box 53, Mosman Park, WA, 6912

## Important notes:

Details provided in your application are not a barrier to employment; the information assists our Recruitment Team in identifying opportunities for appropriate placement of candidates.

If called for interview you will be required to produce original residency documents (ie visa, passport or birth certificate).

If your application is successful, you will be required to provide, at your own expense a National Police Certificate (less than 3 months old).

If a Working with Children Card is a requirement for your position with Rocky Bay, Rocky Bay will meet the cost of applying for this Card.

You will also be required to provide original copies of:

- drivers licence (if required for the position)
- all relevant degrees, professional association memberships/registrations and/or certificates including Senior First Aid
- other employee details, as required.

All Rocky Bay work sites will be smokefree from 1 July 2010.

<b>Section 1: The position with Rocky Bay</b>	
<b>Position details</b>	Position/s applied for:
	Date Available to Start:

<b>Section 2: Personal information</b>			
<b>Personal details</b>	Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Surname:	
	Given names:		
	Preferred name:		
	Address:		
	Suburb:	State:	Postcode:
	Telephone (H):	Telephone (W):	
	Mobile:	Date of Birth (if under 21):	
	Email Address:		
	How would you like us to contact you (eg home phone, mobile?):		
	Languages spoken other than English:		

<b>Permanent residency</b>	Are you an Australian Permanent Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	If NO, please provide valid visa details below with work rights:	
	Visa type/class:	Work condition:
	Issue Date:	Expiry Date: Country:
<b>Drivers licence</b>	Licence Number:	State Of Issue: Expiry Date:
	Class: <input type="checkbox"/> Manual <input type="checkbox"/> Automatic	Type: <input type="checkbox"/> Probationary <input type="checkbox"/> Full
	Endorsements (If any):	
	Do you have a vehicle which you would be prepared to use for work purposes (on receipt of the motor vehicle allowance)? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	Is this vehicle comprehensively insured? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	Have you ever been disqualified from driving? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	If YES, please give reasons: _____ _____ _____	
<b>Previous Rocky Bay experience</b>	Have you ever been employed by Rocky Bay previously? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	If YES, please specify when: from ____/____/____ to ____/____/____	
	Reason for leaving: _____ _____ _____	
	Reason you now wish to work for Rocky Bay: _____ _____ _____	
<b>Language or learning</b>	Would you require additional assistance with learning (ie. such as help with reading, writing, working with numbers, etc)? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	If YES, what help do you require? _____ _____ _____	
<b>Convictions</b>	Do you have any criminal or traffic convictions for any offences from any court, or are you currently the subject of any charge pending before any court? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	If YES, please provide details: _____ _____ _____	

## Section 3: Health

### Important note

Disclosure of a medical condition or restriction does not necessarily exclude an applicant from employment. As part of our selection process Rocky Bay reserves the right to get independent confirmation that candidates are able to perform the tasks associated with the role. We may ask candidates to undertake a function test for this purpose and, if we do, the cost of the examination will be met by Rocky Bay.

Please tick YES or NO to every question. You should answer YES if you have ever suffered injury to the relevant area regardless how long ago it happened. If you answer YES please provide full details in the space provided.

### Personal health history

Infectious diseases – have you had any of the following diseases? *(Please tick box)*

- |   |                                      |                                      |
|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Measles     | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C |

- |               |  |             |
|---------------|--|-------------|
| Immunizations | <input type="checkbox"/> Tetanus                       | Date: _____ |
|               | <input type="checkbox"/> Hepatitis A and B             | Date: _____ |
|               | <input type="checkbox"/> Influenza                     | Date: _____ |
|               | <input type="checkbox"/> Pneumonia                     | Date: _____ |
|               | <input type="checkbox"/> Chicken pox                   | Date: _____ |
|               | <input type="checkbox"/> MMR (Measles, Mumps, Rubella) | Date: _____ |

Do you now or have you ever had any of the following? (please tick box)

	Yes	No	If YES, please give details
Disability, illness or injury that might affect your performance of the role applied for, or necessitate Rocky Bay modifying the work environment (i.e. ramp, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____
Allergy from, or reaction to, any antibiotic, medicines, drugs, insect bites, food or anything else?	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____
Any medical or health related condition that may be affected as a result of being exposed to medications, detergents, cleaning solutions and pesticides? (E.g. respiratory conditions such as asthma, dermatitis or eczema, allergenic reactions, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____
Treatment for an injury, illness or side effect as a result of being exposed to chemical or toxic substances or use of personal protective equipment (e.g. gloves)?	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____
Worker's Compensation claim with a previous employer?	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____

**General background information**

	Yes	No	If YES, please give details
Are you currently receiving medical treatment for any illness or condition?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you currently taking any medications including inhalers?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had an X-ray or scan of your neck and/or back?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had a chest X-ray? If so, when and where?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever spent time in hospital as an in patient?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had an injury or disease resulting from work?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you recently required treatment from a chiropractor or physiotherapist?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you able to wear personal protective equipment without irritation or experiencing problems of any kind? (eg gloves, safety boots, ear muffs/plugs, helmet or safety glasses)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Over the last few years, have you lost time from work because of any illness and/or injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had exposure to any toxic substances or environmental hazards?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever been a patient or worked in a health facility outside WA in the past 12 months? If yes, specify where.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you suffer or have you ever suffered from repetitive strain injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you currently pregnant? If so, what is your due date?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been involved in Motor Vehicle Accident? If so, when?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any physical disability?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is there any history of serious illness or medical conditions in your immediate family?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you lost or gained weight over the past year? If so, how much?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you now have, or have ever had, any of the following: *(please tick box)*

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Defect in sight of either eye	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica, Back pain, back injury
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or predisposition to diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Skin problems eg Dermatitis, Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Defect in hearing	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	Vertigo (fear of heights)	<input type="checkbox"/>	<input type="checkbox"/>	Earache or discharging ears
<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>	Hernia/rupture
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beats, palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble, angina, chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies of any kind
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or duodenal ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing/asthma	<input type="checkbox"/>	<input type="checkbox"/>	Gall/kidney/bladder problems
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis or Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	Colour blindness
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Passing or vomiting blood
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety, panic attacks, insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Goitre or thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or tumour of any kind
<input type="checkbox"/>	<input type="checkbox"/>	Swollen or painful joints	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain and/or injury
<input type="checkbox"/>	<input type="checkbox"/>	Broken or fractured bones, dislocations	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells, blackouts, loss of consciousness
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatics, arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Head injury of concussion
<input type="checkbox"/>	<input type="checkbox"/>	Persistent headaches or migraines	<input type="checkbox"/>	<input type="checkbox"/>	Deep Vein Thrombosis
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Fits	<input type="checkbox"/>	<input type="checkbox"/>	Other joint injuries or conditions
<input type="checkbox"/>	<input type="checkbox"/>	Ankle or Knee trouble or injury	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble or injury
<input type="checkbox"/>	<input type="checkbox"/>	Wrist/elbow trouble or injury	<input type="checkbox"/>	<input type="checkbox"/>	Severe injury or operation
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to bruise or bleed excessively	<input type="checkbox"/>	<input type="checkbox"/>	Spinal problems including whiplash
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder pain and/or injury			

Comment: \_\_\_\_\_  
 \_\_\_\_\_

### Manual handling

Do you have difficulty with any of the following: *(please tick box)*

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Bending down, kneeling, crouching	<input type="checkbox"/>	<input type="checkbox"/>	Working at heights
<input type="checkbox"/>	<input type="checkbox"/>	Lifting heavy objects	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Walking on uneven ground or surfaces	<input type="checkbox"/>	<input type="checkbox"/>	Standing for extended periods of time
<input type="checkbox"/>	<input type="checkbox"/>	Lowering, pushing or pulling heavy objects	<input type="checkbox"/>	<input type="checkbox"/>	Moving, holding or restraining any object
<input type="checkbox"/>	<input type="checkbox"/>	Going up and down stairs or ladders	<input type="checkbox"/>	<input type="checkbox"/>	Crouching/bending/kneeling
<input type="checkbox"/>	<input type="checkbox"/>	Sitting for extended periods of time	<input type="checkbox"/>	<input type="checkbox"/>	Carrying heavy objects

Do you suffer from any medical or health related conditions that may be affected by physical or strenuous work (eg tasks such as those stated above)?  Yes  No

Have you ever been treated for an injury as a result of or while attempting to perform any of the above stated tasks?  Yes  No

If you answered YES to either of the above questions, please provide details in the table below:

Dates	
Nature of Injury/Medical Condition	
What occurred	
Treatment Detail	
Length of Time off Work	

Do you have or have you ever had any other condition not mentioned above that may impact on your ability to safely perform the duties that are required of you? If so, please provide details:

---

---

---

### Health habits and personal safety

Do you:

- Yes  No Smoke or have you ever smoked?  
If YES, how much (per day): \_\_\_\_\_
- Yes  No Exercise regularly?  
If YES, how often (per week) and type: \_\_\_\_\_
- Yes  No Take illicit drugs of any kind?  
If YES, provide details: \_\_\_\_\_
- Yes  No Drink alcohol?  
If YES, average number of standard drinks per week: \_\_\_\_\_

Complete this section ONLY if you are applying for a position as a Disability Support Worker

<b>Section 4:      DISABILITY SUPPORT WORKER / NURSING ROLES ONLY</b>				
<b>Availability</b>				
<b>Working hours</b>	If appointed, are you prepared to?			
	<b>Regularly</b>	<b>Occasionally</b>	<b>Rarely</b>	<b>Not at all</b>
Work night duty (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work shifts (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work flexible hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work on public holidays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please block the hours that you are available to work (by shading the appropriate boxes):

	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am	12pm
<b>Mon</b>												
<b>Tues</b>												
<b>Weds</b>												
<b>Thurs</b>												
<b>Fri</b>												
<b>Sat</b>												
<b>Sun</b>												
<b>Public Holidays</b>												

  

	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm	12am
<b>Mon</b>												
<b>Tues</b>												
<b>Weds</b>												
<b>Thurs</b>												
<b>Fri</b>												
<b>Sat</b>												
<b>Sun</b>												
<b>Public Holidays</b>												

## Section 5: Applicant declaration

I \_\_\_\_\_  
acknowledge that under the terms of Section 79 of the Workers' Compensation and Assistance Act 1981, should a worker, at the time of seeking or entering employment, wilfully and falsely represent himself/herself as not having previously suffered from a disability and subsequently claims compensation for that disability, the insurance company may refuse to award compensation which would otherwise be payable.

Under the Privacy Amendment (Private Sector) Act 2000, I consent to Rocky Bay retaining the information stated herein on file for possible future employment purposes.

I consent to any reference checks which may be necessary to support this application. I understand that Rocky Bay reserves the right to independently verify my Visa, drivers licence (including State Traffic Certificate with certified copy of traffic infringement and demerit points), Working with Children and Police Clearance details, and to access details of any convictions that may be 'spent' (removed from a person's public viewable policy record). I consent to Rocky Bay doing so.

I certify that my answer to each of the above questions is true and that this information is correct. I understand that any misrepresentation of facts in this application could be cause for instant termination if I am employed by Rocky Bay.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Your application should include:

- This form (completed)
- Your resume (providing information about your employment history, qualifications/skills and referees)
- A document matching your skills/experience against the selection criteria for the role

And can be sent to the recruitment team by:

**Email:** [recruitment@rockybay.org.au](mailto:recruitment@rockybay.org.au)

**Fax:** (08) 9383.1230

**Post:** Human Resources Team, PO Box 53, Mosman Park WA 6912

**Personal delivery:** Human Resources Team, 60 McCabe Street, Mosman Park WA 6012

<b>Recruitment source</b>	Where did you see this vacancy advertised?
	<input type="checkbox"/> Rocky Bay website
	<input type="checkbox"/> SEEK website
	<input type="checkbox"/> Other website (please specify) _____
	<input type="checkbox"/> West Australian newspaper
	<input type="checkbox"/> Other newspaper (please specify) _____
	<input type="checkbox"/> Word Of Mouth
<input type="checkbox"/> Other source (please specify) _____	