Cobram District Health

TO BE COMPLETED BY APPLICANT			
Position applied for:			
Surname:		Given names:	
Address:	No & Street		
	Suburb/Town	Postcode:	
Phone:	Work: ( )	Home: ( )	
	Mobile:	E-mail:	

1. Please list and provide copies of Qualifications (including post graduate):

2. Do you have other employment that you intend maintaining if successful with this position?

☐ Yes. If Yes please provide details	☐ No

3. Are you an Australian Citizen or Permanent Resident:

☐ Yes	☐ No, If No please attached proof of your eligibility to maintain employment within Australia.

4. Have you lived or worked overseas for more than 6 months since tuning 18 years Old?

☐ Yes If yes, please provide CDH with a signed Statuary Declaration stating that you do not have criminal record in the country your resided in.	☐ No

5. Have you received a redundancy payment from any employer in the past 12 months?

☐ Yes If yes, please provide details:	☐ No

6. I confirm I have read the inherent job requirements and job demands for the position. (please tick the appropriate statement below)		
☐ I am not aware of any health conditions that might interfere with my ability to perform the inherent job requirements and job demands of this position.		
☐ I have a health condition that may require the employer to provide me with the services or facilities s (adjustments) so that I can successfully carry out the inherent job requirements and job demands of this position.		
Please list details of all pre – existing conditions:		
☐ I am aware that any false or misleading statements may threaten my appointment or continued employment.		
☐ I acknowledge and declare that the information provided in this form is true and correct.		
Attach a copy of CV including two referees.		
Signature of Applicant:	Date:	
For Allied Health and Nursing:		
6. Copy of Registration Certificate:	Yes ☐	Not applicable: ☐
Registration No:		
7. Professional Indemnity Insurance:	Yes ☐	No ☐
If yes Insurance company:		
Contact name:	Phone:	
Policy No:		
8. Any disciplinary proceedings in the past or currently being addressed:	Yes ☐	No ☐
If yes, please give details		
9. (i)Membership of professional association(s) Please provide details including membership number(s)		
6. (ii) Details of Accredited Practitioner status – attach Copy of documentation		
TO BE COMPLETED BY DEPARTMENT MANAGER:		
Verified by: Date:	Signed:	
Review due:		