BETHESDA HOSPITAL

APPLICATION FOR EMPLOYMENT

Full Name: _____

Position Title: _____

Reference Number: _____ Location: _____

Current Bethesda Hospital Staff only:

Current Position: _____ Current Location: _____

Date Received _____

Initial Rating _____

Privacy: Your application form contains personal information which will be dealt with in accordance with our Privacy Policy. If you are successful in your application, your form will become an employment record. If you are unsuccessful your application form will be destroyed/kept for 3 months before being destroyed.

APPLICATION FOR EMPLOYMENT

PERSONAL DETAILS:

First Name(s):		Last Name:	
Preferred Name:			
Title:	Dr.☐ Mr.☐ Mrs.☐ Miss.☐ Ms☐	Gender:	Male ☐ Female ☐
Home Address:		Contact Numbers:	Home: Mobile: Work:
E-mail Address:		Preferred Contact by:	
Date of Birth	(For admin purposes only)		

Registration Details: (If applicable)			
Date registered in WA		Registration Number: Expiry Date:	

ADDITIONAL INFORMATION:

Availability: Days: M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S ☐			
Times: Days ☐ Evenings ☐ Nights ☐			
First Aid Certificate:	YES/NO	Type:	
Drivers Licence:	YES/NO	Number:	
Have you worked for the organisation before?			YES/NO
If yes, position held and location:			
Are you an Australian citizen?			YES/NO
If no, have you been granted permanent residency			YES/NO
If no, have you been granted a temporary visa/work permit			YES/NO
If yes, state the period that the visa/work permit is valid.			From: To: Visa Number:

PAGE NOT REQUIRED TO BE COMPLETED IF ATTACHING CV.

EDUCATION/QUALIFICATIONS/TRAINING:

Please give details of any qualifications obtained, training courses attended or examinations taken if you are still awaiting the results.

Year – From – To	Name of school/college	Qualification attained

Year – From – To	Name of school/college	Qualification attained

Year – From – To	Name of school/college	Qualification attained

Year – From – To	Name of school/college	Qualification attained

Year – From – To	Name of school/college	Qualification attained

PAGE NOT REQUIRED TO BE COMPLETED IF ATTACHING CV.

EMPLOYMENT HISTORY:

Please include details of any previous voluntary/unpaid work, Bethesda employment and periods of unemployment.

Employer:	
Position Held / Main Duties:	
Dates: From - To	
Reason of leaving:	

Employer:	
Position Held / Main Duties:	
Dates: From - To	
Reason of leaving:	

Employer:	
Position Held / Main Duties:	
Dates: From - To	

Reason of leaving:	

Employer:	
Position Held / Main Duties:	
Dates: From - To	
Reason of leaving:	

APPLICATION DETAILS

In the space provided below, explain why you are applying for this position. Please indicate all relevant skills and experience you have, which you believe would enable you to successfully carry out the duties and responsibilities of this position

AVAILABILITY

Please give below your interview availability, and any upcoming events or holidays planned.

REFEREES:

Please include two referee's with at least one being your current or last employer.

Name	Position
Company/Relationship	Contact Number
Name	Position
Company/Relationship	Contact Number

PRE-EMPLOYMENT HEALTH QUESTIONNAIRE:

No	Do you have or have you had any of the following conditions? If yes please provided further details in the table below.	Answer	
		YES	NO
1	Heart disease, heart attack or angina, high blood pressure	☐	☐
2	Asthma, wheeze or lung disease	☐	☐
3	Abdominal ulcers or hernia	☐	☐
4	Frequent or regular migraine / headaches	☐	☐
5	Allergies or sinusitis	☐	☐
6	Eczema, dermatitis or other skin complaints	☐	☐
7	Anxiety, panic attacks or psychiatric illness including depression	☐	☐
8	Visual problems that cannot be corrected by prescription glasses	☐	☐
9	Ear conditions such as deafness or tinnitus	☐	☐
10	Blood borne viruses including Hepatitis B, Hepatitis C or human immunodeficiency virus (HIV)	☐	☐
11	Immunosuppressed including receiving chemotherapy or long term steroid use	☐	☐
12	Have you ever been treated for drug or alcohol addiction	☐	☐
13	Diabetes	☐	☐
14	Previous back, neck or spinal injury including whiplash	☐	☐
15	Sciatica or disc protrusion	☐	☐
16	Back pain	☐	☐
17	Spinal operation	☐	☐
18	Arthritis / rheumatism	☐	☐
19	Hip / knee / ankle injury	☐	☐
20	Shoulder / elbow / wrist injury	☐	☐
21	Chronic joint injury including stiffness or pain	☐	☐
22	Shoulder or hip bursitis	☐	☐
23	RSI / Occupational overuse syndrome	☐	☐
24	Bleeding disorder	☐	☐
25	Muscle / tendon or ligament problem	☐	☐
26	Carpel tunnel syndrome	☐	☐
27	Epilepsy, fainting, fits, blackouts or dizzy spells	☐	☐
28	Any sporting / vehicle or work-related illness or injury	☐	☐
29	Have you ever been discharged or resigned from a job for medical reasons	☐	☐
30	Have you had an application for Superannuation, Life Insurance or similar rejected on medical grounds.	☐	☐
31	Are you a smoker? If yes how many daily	☐	☐
32	Have you worked in or been a patient in a hospital outside of Western Australia during the past 12 months	☐	☐
33	Have you ever been injured at work, suffered from a work related illness or submitted a Workers' Compensation or Insurance Commission of WA (ICWA), previously MVIT, claim.	☐	☐

For any questions above (1 – 35) answered yes, complete the table below. If you require more space than provided here, please continue on an additional sheet.

No	Duration and Dates of Condition	Current Status

- If you fail to disclose information about a pre-existing medical condition, or workers compensation claim, your claim may be pended as declined.
- Do you believe you are fit and physically able to fulfil all the duties required in the role applied for? YES/NO

If no, what modifications would be required?

DECLARATION:

- My answers relating to my medical and employment history are true and complete to the best of my knowledge. Furthermore, there is nothing else regarding my health, well being or ability to carry out the potential role which Bethesda Hospital may need to know to assess me for the position(s) I have applied.
- I am fully aware that if I fail to disclose any relevant mater relating to my health, which renders me incapable of properly fulfilling the duties of the position, the employer may not employ me and if already employed by the employer, my employment may be summarily terminated.
- I consent to any reference checks which may be necessary to support this application.

Signature:		Date:	
(if you are applying electronically, you will be required to sign a printout of this application should you proceed in the selection process)			

Return details:

Please return your application for the attention of the recruiting Manager quoting the reference number via one of the methods below:

Submit via e-mail as an attachment to	HRonboarding@bethesda.org.au
Or Fax to	
Or Mail /deliver to	Bethesda Hospital, 25 Queenslea Drive Claremont WA 6010

PRE EMPLOYMENT IMMUNISATION AND SCREENING REQUIREMENTS

ALL sections on the pre employment screening form must be completed.

Failure to provide required evidence will impact on your eligibility for employment.

IMMUNISATION IS IMPORTANT FOR HEALTHCARE WORKERS (HCW'S) *(this includes all staff at Bethesda)* AND VOLUNTEERS.

HCW's are at risk of exposure to vaccine preventable diseases while at work. Immunisation protects your health, prevents diseases being spread between you and your family and between you and your patients.

All HCW's must undergo pre employment screening and vaccination relevant to their role to minimise the risk of disease acquisition and transmission.

Routine screening /immunisation based on risk assessment may include;

DISEASE	VACCINATION
Measles, mumps, rubella	MMR vaccine x 2 doses (1 month apart)
Varicella (chickenpox)	Varicella x 2 doses (1 month apart)
Pertussis (whooping cough)	Pertussis vaccine within the last 10 years
Hepatitis B	Age appropriate vaccination schedule followed by serological evidence
Influenza	Annual vaccination
Tuberculosis screening	Mantoux /quantiferon

IMPORTANT INFORMATION FOR APPLICANTS

Written evidence in English MUST be provided to support history of natural infection or prior vaccination for measles, mumps, rubella, pertussis, varicella and hepatitis B as outlined above.

Evidence must be provided for tuberculosis (TB) screening and MRSA. In most cases, these requirements can be determined once your form is reviewed by your manager.

Evidence that will be accepted includes:

- complete vaccination records (to support required number of doses of vaccine);
- serology / blood test results, or letter signed by a GP; or
- results of either a baseline Mantoux test or Quantiferon blood test.

You may have had screening done recently (perhaps at another healthcare facility). You are requested to access these results and provide a copy to your manager at Bethesda Health Care with your completed form.

Should you:

- ❖ not be able to provide the required evidence as listed above, you will be required to undergo further testing;
- ❖ due to allergy or medical reasons, not be able to receive vaccinations or undergo Mantoux testing - a signed letter from your GP/Specialist will be required; or

suffer from ANY infectious disease this needs to be declared and you **MUST** discuss your work practices with the Manager, Infection Prevention & Control or your doctor.

APPLICATION FOR EMPLOYMENT

PLEASE READ CAREFULLY AND COMPLETE ALL SECTIONS A, B, C, D & E

Bethesda Health Care is committed to providing an environment, which is as safe as possible for all healthcare workers (HCW's), volunteers and patients. Your employment with Bethesda Health Care is subject to you having current immunity status that complies with the Department of Health Western Australia Operational Directive OD0388/12 and National Guidelines. All information provided in this checklist will be treated confidentially and this information will be stored in a secure place.

Surname:	**Given name:**		**Date of birth:** M ☐ F ☐
Current address:			
			Postcode:
Telephone:	**Home:**	**Mobile:**	**Start date:**
Home email address:			**Payroll No:** *(issued by Bethesda)*
Position title:		**Department:**	

SECTION A - MRSA *(If YES to either question, MRSA screening is required before you can work clinically) tick YES or NO*	**Yes ☑**	**No ☑**	**OFFICE USE ONLY ↓**
Have you worked or been a patient in a hospital outside WA in the past 12 months?	☐	☐	
Have you worked in a residential care facility / nursing home outside of WA in the past 12 months?	☐	☐	

SECTION B - Communicable Diseases *(Vaccine Preventable)*	**Minimum acceptable evidence of immunity**	**Yes ☑**	**OFFICE USE ONLY ↓ *(Date/result)***
Measles Mumps Rubella	Documented evidence of two measles, mumps and rubella vaccinations at least 1 month apart; **OR** Born before 1966 (measles only); **OR** Presence of measles, mumps and rubella antibody (IgG) on serology.	☐ ☐ ☐	
Varicella *(Chicken Pox)*	Documented evidence of two varicella vaccinations at least 1 month apart, **OR** Presence of varicella antibody (IgG) on serology	☐ ☐	
Pertussis	One documented dose of adult diphtheria, tetanus and pertussis (dtpa) vaccine in the last 10 years	☐	

SECTION C - Hepatitis B Immunisation *(All healthcare workers and volunteers to complete)*	**Yes ☑**	
Documented evidence of an age appropriate vaccination schedule for hepatitis B?	☐	
Presence of Hepatitis B Antibody on Serology (Blood Test)?	☐	

Office use: *(Comments/action)*	

SECTION D - Assessment of Risk of TB in HCW's and Volunteers

What is the Risk of TB infection?			OFFICE USE ONLY *(this shaded area)* YES ☑	NO ☑
1.	Have you been treated for TB in the past? ☐ Yes ☐ No		☐	☐
2.	Have you had contact, personally or at work, with somebody who suffered from TB? ☐ Yes ☐ No		☐	☐
3.	Country of birth		TB incidence >50/10^5* ☐	☐
4.	What countries have you lived or worked in for more than six months, other than your country of birth?		TB incidence >50/10^5*	
			☐	☐
			☐	☐
5.	Are you Aboriginal or a Torres Strait Islander? ☐Yes ☐ No		☐	☐

OFFICE USE ONLY If "Y" to ANY of the above, then Group 2 (yellow) in algorithm (Appendix B)

*For country based TB incidence refer to http://www.phac-aspc.gc.ca/tbpc-latb/itir-eng.php

Other information *(Copy of results MUST be attached)*

Have you had a Mantoux or Quantiferon skin test before?	☐ Yes	☐ No	Result: _____		
Have you had BCG vaccination?	☐ Yes	☐ No	When: _____		
Do you have a medical history of immune deficiency		☐ Yes	☐ No		
or take medicines that reduce immune response?		☐ Yes	☐ No		
Are you a permanent resident / citizen of Australia?	☐ Yes	☐ No	Visa expiry date _____		

SECTION E - ALLERGIES - DRUGS/OTHER

Allergies / drugs / other:	☐ Yes	☐ No	If yes, please list below
Skin conditions:	☐ Yes	☐ No	If yes, please list below

Please return this form with the ATTACHED EVIDENCE along with your application.
If you have any questions, or are having difficulty in obtaining the evidence required to enable you to commence employment, please contact the Manager, Infection Prevention & Control on 9340 6300 or via email – InfectionControl@bethesda.org.au

Employee Signature: _____ **Date:** _____

INTERNAL USE ONLY

ATTENTION MANAGERS

This section is completed by the department manager after review of the completed form and evidence provided by the potential employee. Following review and action to address outstanding results, forward all forms/results to the Manager, Infection Prevention & Control.

Name		Date	
Department		Contact number	