Date:	Contact Information
Name:	Home:
Address:	Mobile:
	Work:
DOB (optional):	Email:

Qualifications (Tertiary, TAFE, Short courses):

Licenses, Tickets, Accreditations:

Previous/Current Role:

Current Employment Status: Employed: ☐ Unemployed: ☐

Preferred Occupation:	**F/T**	**P/T**	**Temp**	**Preferred Hours**
1.	☐	☐	☐	
2.	☐	☐	☐	
3.	☐	☐	☐	

Salary: $ **Hourly Rate:** $

Computer Skills/Software (If Applicable)

	Basic	**Intermediate**	**Advanced**
Word	☐	☐	☐
Excel	☐	☐	☐
Outlook	☐	☐	☐
Internet	☐	☐	☐
MYOB	☐	☐	☐
Quickbooks	☐	☐	☐
Other:	☐	☐	☐

Typing Speed:

D/E Key Strokes:

PTO

Health Details

The Occupational Health and Safety Act stipulates employers have a duty of care for their employees, and to be mindful of not exposing employees to any risks or danger to health, so far as is practicable.
So that our employees are not placed into an assignment that may have an associated risk to ones' health or safety, we need to ensure that you are capable of performing tasks that you may be considered for.

This information is confidential and will not be used for any other purpose without your written consent.

1. Do you have any medical conditions that may affect the health and safety of yourself or others in the workplace?
   Yes **No** **Details:** _____
2. Do you suffer from any allergies?
   Yes **No** **Details:** _____
3. Do you experience or suffer from any of the following conditions or have had in the past?

□ Hearing	□ Working at heights	□ Migraine/Severe Headaches
□ Nervous Disorder	□ Anxiety/Stress	□ Depression
□ Epilepsy	□ RSI/Carpel Tunnel	□ Shoulder Conditions
□ Arm/Wrist/Hand condition	□ Back injury/Conditions	□ Bending/Twisting
□ Asthma/Shortness of breath	□ Diabetes	□ Walking/Standing for long periods
□ Blood conditions/virus	□ Respiratory conditions	□ Fainting/Dizziness
□ Substance dependence	□ Heart Conditions	□ Smoking

   Please provide details for any boxes you have ticked: _____
   _____

4. Do you have any pre-existing injuries, disease or medical conditions that could be affected by any manual handling tasks?
   Yes No Details: _____
5. Have you ever been injured at work?
   Yes No Details: _____
6. Do you, or are you required to take drugs or medications that may affect your ability to perform any tasks?
   Yes No Details: _____

Any additional information regarding the above health information that may affect your performance in the workplace: _____

Signature: _____

*** mp** personnel and training will keep your resume on file for 3-4 months and should an appropriate position become available, we will contact you.
* **mp** personnel and training are required under the Recruitment and Consulting Services Association to abide and maintain all clients confidentiality in accordance with the Privacy Act 2005.