



ELSDON PTY LTD
AS TRUSTEE FOR
THE CAYS FAMILY TRUST
T/A CAYS ENGINEERING & SUPPLY
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APPLICATION FOR EMPLOYMENT

WORKSHOP / ONSITE

IMPORTANT PLEASE READ THIS SECTION BEFORE YOU START

The information you provide in this application form will assist in evaluating your suitability for employment with Cays Engineering so it is important to:-

- Clearly print all responses
- Ensure all sections are completed.
- A résumé may be attached if you think it will provide additional information.
- Attach photocopies of any supporting documentation (qualifications, certificates, trade papers, references etc.) Do not attach originals.
- Ensure all sections are answered honestly and to the best of your ability.
- Applications are filed on record for approximately six months.

Please note:

The acceptance by Cays Engineering of this application form does not guarantee employment.



EMPLOYMENT APPLICATION FORM – WORKSHOP STAFF

Date of Application:

Personal Details

Surname: _____ Given Names: _____ DOB: _____

Phone No: _____ Mobile No: _____ Email-ID: _____

Drivers License No: _____ Class: _____ Expiry: _____

Address: _____

Suburb: _____ Postcode: _____

Mailing Address: _____

Suburb: _____ Postcode: _____

Next of Kin: _____ Contact No.: _____ Relationship: _____

Are you an Australian citizen? _____

If you are not an Australian citizen please attach details of the immigration visa permit which allows you to legally work in Australia.

Position Type:

Workshop

Onsite

Position Applying For: _____

Is this your usual occupation? _____ Years experience: _____

Educational Qualifications:

Year from/to	Name of Institution	Standard/Qualification achieved

Trade Qualifications:

Please attach a copy of any trade certificates/ licences.

Trade Qualifications _____ Year completed: _____

Where did you complete your trade qualifications? _____

Employment History

(Please list details of the last three positions held)

Period of Employment	Name of Employer	Position held and main duties

Referees

(Please list below three referees whom we can contact regarding your suitability for the position)

	Name	Position	Company	Contact Number
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Operating Experience

Please tick relevant experience.

- | | |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> CRANES | <input type="checkbox"/> TRUCK |
| <input type="checkbox"/> Mobile | <input type="checkbox"/> Flat Tops |
| <input type="checkbox"/> Overhead | <input type="checkbox"/> Hiab |

Industry Training / Certificates of Competency

Please attach copies of any national certificates, company "in house" certificates of training records documented experience.

CRANE OPERATOR

- Non slewing mobile crane (CN) (greater than 3 tonnes capacity)
- Slewing mobile crane: Up to 20T(C2) Up to 60T (C6) Up to 100T (C1) Open (CO)
- Tower cranes (CT) What type and capacity have you operated? _____
- Other cranes What type and capacity have you operated? _____

HOISTS

- Material Hoists (HM) (Cantilever Platforms) Personal and Material (HP) Hoists

SCAFFOLDING

- Basic (SB) Intermediate (SI) Advanced (SA)

RIGGING

- Basic (RB) Intermediate (RI) Advanced (RA)

- DOGGING (RG) FORKLIFT (RL)

- FIRST AID ELEVATED WORK PLATFORM (WP) CONCRETE PLACING BOOM (PB)

- MOBILE PLANT What types and capacity? _____

Employment Information

If offered the position when are you available to start? _____

Are you available to work:-

- Afternoon shift
 Night shift
 Weekends
 Public Holidays

Fitness

It is important that you are medically fit to perform the duties associated with the occupation or position you are applying for.

If requested do you agree to undergo a full medical (including illegal drugs)?.....

Will you give the authority to perform random drug and alcohol screens when required?.....

The physical requirements of this position are as follows:

- Lifting upto 20 kilograms
- Carrying loads of upto 10 kilograms
- Carrying loads up multiple flights of stairs
- Standing for upto 3 hours
- Use of scaffolds/ladders
- Working at heights
- Exposure to Noise
- Exposure to Hot Humid and Dusty Conditions
- Exposure to Grease and Oils
- Exposure Petrol and Solvents
- Exposure to Welding fumes and other Atmospheric contaminants

Are you aware of any health problem or medical condition which might affect your ability to perform the physical requirements of this position? If so, please provide details

.....



BEFORE SIGNING THE DECLARATON BELOW, PLEASE TAKE THE TIME TO REVIEW YOUR RESPONSES AND ENSURE ALL DETAILS ARE COMPLETE AND CORRECT.

Declaration

I certify that the answers, information and statements given on this form are correct and to the best of my knowledge. I understand Cays Engineering reserves the right to verify all information. I further understand that any false or misleading detail will make this application invalid and if I am employed by Cays Engineering such falsifications or misinformation will be considered serious and may result in the termination of my employment.

Signed _____ Date _____

MEDICAL QUESTIONNAIRE

Note: This questionnaire may be reviewed by a medical practitioner.
You may be required to attend a full medical examination.
Attendance of a medical Examination does not guarantee employment

Date:.....

Name:

Position Applying For:.....

1.What is your average intake of:

Alcohol?	Cigarettes?	Recreational Drugs?

2.Do you have any allergies to:

Medication?	Foods?	Other?

3.Please place a tick (✓) in the box beside any condition/s that you have currently or had at any time. Please provide details if you have ticked a box.

Heart Conditions: Stroke/ Angina/High Blood Pressure	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	
Lung conditions: Asthma / Bronchitis / Pneumonia / Tuberculosis / Shortness of Breath / Chest Injuries / Wheezing	<input type="checkbox"/>	
Fits/Seizures/Blackouts	<input type="checkbox"/>	
Arthritis/Rheumatism	<input type="checkbox"/>	
Back/Lower Back injuries	<input type="checkbox"/>	
Loss of hearing/Injury to ears including broken eardrum/Hearing Aids	<input type="checkbox"/>	
Vision problems	<input type="checkbox"/>	
Skin disorders/Dermatitis	<input type="checkbox"/>	
Hepatitis/Jaundice/Liver trouble	<input type="checkbox"/>	
Persistent Headaches/Migraines	<input type="checkbox"/>	
Any joint problems/fractures	<input type="checkbox"/>	
Mental or nervous troubles /Depression	<input type="checkbox"/>	
Hernia	<input type="checkbox"/>	
Stomach problems/Ulcers	<input type="checkbox"/>	
Trouble smelling odours	<input type="checkbox"/>	
NONE of the above	<input type="checkbox"/>	

MEDICAL QUESTIONNAIRE

4. Do you currently take medication for any of the following conditions?

Heart	<input type="checkbox"/>	
Breathing or Lung Problems	<input type="checkbox"/>	
Blood Pressure	<input type="checkbox"/>	
Seizure (fits)	<input type="checkbox"/>	
Other (Please give details)	<input type="checkbox"/>	

5. Please place a tick (✓) in the box beside any activity with which you have difficulty. Give details if you have ticked a box.

Understanding English	<input type="checkbox"/>	
Running	<input type="checkbox"/>	
Crouching	<input type="checkbox"/>	
Kneeling	<input type="checkbox"/>	
Walking on rough uneven ground	<input type="checkbox"/>	
Standing for more than 2 hours	<input type="checkbox"/>	
Sitting for more than 2 hours	<input type="checkbox"/>	
Confined Spaces	<input type="checkbox"/>	
Heights/High Altitudes	<input type="checkbox"/>	
Lifting or Bending	<input type="checkbox"/>	
Climbing a ladder	<input type="checkbox"/>	
Hearing a normal conversation	<input type="checkbox"/>	
Reading ordinary print	<input type="checkbox"/>	
Concentration	<input type="checkbox"/>	
Turning your head rapidly	<input type="checkbox"/>	
Using hand tools	<input type="checkbox"/>	
Repetitive movements of hands/arms	<input type="checkbox"/>	
Gripping firmly with both hands	<input type="checkbox"/>	

MEDICAL QUESTIONNAIRE

6. Have you worked with or had any exposure to the following

Loud noise/explosives/gunfire	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>
Asbestos	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>
Chemicals	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>
Radiation	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>
Dust	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>
Any other hazardous exposure	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>

Declaration

I solemnly declare that each and every answer above is true to the best of my knowledge and belief. I understand that any false or misleading information may result in termination of employment. I understand that I may also be required to undergo a hearing test on termination of employment.

Statement Authorisation

I hereby authorise the examining doctor to submit a medical report regarding the above statements, physical findings, audiogram and all other investigations to my employer.

Applicant's Signature	<input type="text"/>	Date	<input type="text"/>
Doctor's Comments	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>		
Doctor's Signature	<input type="text"/>	Date	<input type="text"/>