



CONFIDENTIAL

P.O. BOX 120  
KURRI KURRI NSW 2327  
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J.R. BURNETT PTY LIMITED. A.C.N. 001 457 665

APPLICATION  
FOR  
EMPLOYMENT

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Position applied for: \_\_\_\_\_

None of the information which you give in this CONFIDENTIAL document will be disclosed without your permission.

OFFICE USE ONLY	
Interview	
Medical	
Comments:	

**PERSONAL DATA**

SURNAME:

Mr.  
Mrs.  
Miss.

FIRST NAME:

ADDRESS:

Post Code:

Licence No.

TELEPHONE No.:

( )  
( )

DATE OF BIRTH:

PLACE OF BIRTH (City &amp; Country)

 MARRIED  SINGLE  
No. of Dependents:**EMERGENCY CONTACT**Name of Person:  
Relationship:

Address:

Telephone No.  
( )Have you previously worked at an abattoirs ?  Yes  
 No

If Yes, please give dates, position(s) held and location:

Have you previously applied for a job with this company ?  Yes  
 No

If Yes, please give details:

**POSITION DESIRED**

Type of position desired:

Are you able to perform all of the duties of the job for which you are applying ?  Yes  No

If No, Describe the duties and function you cannot perform and why ?

What prompted your application to Kurri Meats ?

- Advertisement  Friend  
 Employment Agency  Relative  
 Walk-in  Other

**EDUCATION AND TRAINING**

Secondary Education

Period:	School(s) attended:	Major Subjects:	Level Passed:
From: To:			

**TECHNICAL AND FURTHER EDUCATION**

Period:	Apprenticeship, Tech, College, Uni etc.	<input type="checkbox"/> Full time <input type="checkbox"/> Part time	Major Subjects:	Other Qualifications Obtained:
From: To:				
		<input type="checkbox"/> Full time <input type="checkbox"/> Part time		
		<input type="checkbox"/> Full time <input type="checkbox"/> Part time		
		<input type="checkbox"/> Full time <input type="checkbox"/> Part time		

OCCUPATIONAL LICENCES AND REGISTRATION CERTIFICATES HELD INCLUDING FIRST AID:



<b>SECTION A - MEDICAL HISTORY - Confidential</b>		
Name of Company: Kurri Meats		
Job Specification:		
This part of the form is to be filled in by the Applicant and signed. If You are in doubt, leave a blank		
Surname:		First Name:
Address:		
Date of Birth:		Contact telephone number:
Marital Status:		No of children:
Name of Family Doctor:		
Address of Family Doctor:		
<b>Personal History</b>		
Do you suffer from or have you ever had: (tick if 'YES' and give details below)		
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Fits/epilepsy	<input type="checkbox"/> Asbestosis or Silicosis
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Mental/nervous disorder	<input type="checkbox"/> Repetition Strain
<input type="checkbox"/> Palpitations/irregular heartbeat	<input type="checkbox"/> Headache/migraine/giddiness	<input type="checkbox"/> Overuse Syndrome
<input type="checkbox"/> Chest pain/angina	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Varicose Veins causing trouble
<input type="checkbox"/> Rheumatic fever/heart murmur	<input type="checkbox"/> Back pain/injury/sciatica	<input type="checkbox"/> Warts
<input type="checkbox"/> Stroke	<input type="checkbox"/> Joint pain or injury/arthritis	<input type="checkbox"/> Strain or Sprain of any kind
<input type="checkbox"/> Wheeze/asthma/bronchitis	<input type="checkbox"/> Foot trouble	<input type="checkbox"/> Allergies eg. Penicillin
<input type="checkbox"/> TB/emphysema	<input type="checkbox"/> Muscle/tendon trouble/tenosynovitis	<input type="checkbox"/> Gastroenteritis
<input type="checkbox"/> Pneumonia, pleurisy	<input type="checkbox"/> Painful arm/tennis elbow/shoulder/wrist	<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Hay fever, sinusitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Recurrent Indigestion/Dyspepsia
<input type="checkbox"/> Stomach/peptic/duodenal ulcer	<input type="checkbox"/> Skin disorders/rashes	<input type="checkbox"/> Typhoid or Paratyphoid
<input type="checkbox"/> Passing/vomiting blood	<input type="checkbox"/> Eye/vision problem	<input type="checkbox"/> Any chronic Illness or Disease
<input type="checkbox"/> Indigestion/bowl disorder	<input type="checkbox"/> Ear/hearing problem	<input type="checkbox"/> Any Accident or Operation
<input type="checkbox"/> Jaundice/hepatitis/gallstones	<input type="checkbox"/> Head/neck injury/whiplash/concussion	<input type="checkbox"/> Any other undeclared condition
<input type="checkbox"/> Kidney/bladder disease/stones	<input type="checkbox"/> Anxiety/fear of heights/confined spaces	<input type="checkbox"/> Serious Injury
<input type="checkbox"/> Blackouts/fainting attacks	<input type="checkbox"/> Any other illness	<input type="checkbox"/> Have you ever been admitted to hospital ?
Details...		
Have you left a job or been discharged from H.M. Forces because of ill-health ?		
If 'YES' please give dates and details:		
Have you ever had a health examination for employment, insurance or superannuation ? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes please give dates and details:		

