



“Providing care services for individuals to improve their independence.”

9 Fairlie Street, Hamlyn Heights 3215
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 Email: geelong@bestofcarebarwon.com.au

POSITION APPLIED FOR:	
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DATE :	/	/
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SURNAME:		FIRST NAME(S):	
DATE OF BIRTH:	/	/	GENDER:
			Male / Female
ADDRESS:		POSTCODE:	
SUBURB:	PRIVATE PHONE:	Do you have an answering machine/voicemail on this phone?	
		Yes / No	
EMAIL:	MOBILE PHONE:	Does your mobile have voicemail?	
		Yes / No	

YOU MAY BE ASKED TO TRANSPORT CLIENTS IF YOU HAVE THE FOLLOWING:

DO YOU HAVE ACCESS TO A RELIABLE MOTOR VEHICLE?	Yes / No	
DO YOU HAVE COMPREHENSIVE CAR INSURANCE?	Yes / No	

STRENGTHS & SKILLS:

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CERTIFICATES / COURSES ATTENDED *(Include care attendant, child, aged and disability care, first aid)*

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ARE YOU HOIST TRAINED?	No	Yes	Overhead	Standing frame	Portable
DO YOU KNOW SIGN LANGUAGE?	No	Yes	Very well	Moderately	Minimal
LANGUAGES SPOKEN:				



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WHO WERE/ARE YOUR PREVIOUS FOUR EMPLOYERS?

EMPLOYER	TASKS PERFORMED	CONTACT PHONE	EMPLOYMENT CEASED
(1)			
(2)			
(3)			
(4)			

PLEASE INDICATE THE TYPE OF WORK YOU CAN UNDERTAKE

CHILDCARE**

Baby sitting and child minding YES / NO

Children with disabilities (i.e. physical, intellectual, autism) YES / NO

DISABILITIES CARE

Physical (including using hoists, lifting and transferring) YES / NO

Intellectual & ADHD (including autism & challenging behaviours) YES / NO

Neurological (including Parkinson’s, Motor Neuron Disease, Epilepsy & MS) YES / NO

Acquired Brain Injury YES / NO

Mental health/ Psychiatric YES / NO

Dementia YES / NO

DOMESTIC CLEANING YES / NO

ELDER CARE** (can include respite for carers, cleaning, shopping, banking, etc.) YES / NO

PERSONAL CARE** - recognised qualification or nurse training required
Includes personal care – shower assist, hygiene, dressing assist, lifting/transfer techniques YES / NO

RELIEVING SHIFTS AT NURSING HOMES** YES / NO

HOME NURSING – Nursing Registration required YES / NO

PALLIATIVE CARE ** YES / NO

**** Current senior first aid certificate required**

Additional Comments:

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DO YOU HAVE ANY ALLERGIES? (i.e. cats, household cleaners, items found around the house)

PLEASE INDICATE THE TIMES WHEN YOU WILL BE AVAILABLE TO UNDERTAKE WORK

✓ = Available

O = Occasionally

* = Not available at all

Table with 8 columns (AVAILABILITY, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Sunday) and 7 rows (6.00am - 9.00 am, 9.00am - 12.00md, 12.00md - 3.00 pm, 3.00pm - 6.00pm, 6.00pm - 12.00mn, Sleepovers)

Comments about your availability:

How many hours would you prefer to work with Best of Care per week? _____

Do you currently have other employment that you need to work around? Yes / No

Are you intending on applying for other positions? Yes / No

Note: Being honest in answering the following questions will not jeopardise your employment with Best of Care. Your response will make sure we place you in an appropriate setting.



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WORKCOVER ISSUES TO BE AWARE OF:

Under legislation and section S.82 (7) and (8) of the Accident Compensation Act of 1985, before you are employed, we are obligated to ask you if you have any pre-existing injury or disease that you are aware of that might be affected by the work you are employed to do.

If you do not disclose the information or if you give false information and the injury or disease recurs or gets worse, you may not be entitled to Work Cover compensation for that particular injury or disease.

1. Please state any pre-existing injuries.

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2. Have you ever received payments under the Workers Compensation/Workcare 1985 Act? **Yes / No**
 If yes, please give details.

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AT TIMES YOU MAY NEED TO USE THE COMPANY CAR AND WE NEED TO ASK YOU THE FOLLOWING QUESTIONS FOR INSURANCE COVERAGE.

(Failure to answer this questionnaire correctly will result in the Insurance Company not covering you in case of any accidents.)

1. Do you have a current licence? YES NO

Licence Number.....

2. Have you been refused an Insurance Policy? YES NO

3. Have you ever been cited for or lost your licence for being over .05? YES NO

NB: Please note Best of Care must be notified if any of the above conditions occur whilst in our employment.

IN CASE OF AN ACCIDENT OR AN ILLNESS WHOM SHOULD THE AGENCY CONTACT?

NAME:	RELATIONSHIP:
TELEPHONE: (Work)	TELEPHONE: (Home)

REFERENCES

NAME	RELATIONSHIP	TELEPHONE
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CHARACTER REFEREES

(1)

(2)

WORKPLACE REFEREES

(1)

(2)

NB: We will contact two referees. Please include at least one workplace referee.

WHAT DO YOU WANT TO ACHIEVE IN YOUR WORK WITH US?

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HOW DID YOU HEAR ABOUT OUR SERVICE?

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NOTE: This information will be treated as confidential

I CERTIFY THAT THESE PARTICULARS ARE, TO THE BEST OF MY KNOWLEDGE, TRUE AND CORRECT IN EVERY DETAIL AND THAT I HAVE NOT KNOWINGLY OR DELIBERATELY PROVIDED ANY FALSE, INACCURATE OR MISLEADING INFORMATION. I ACKNOWLEDGE THAT THE PROVISION OF SUCH FALSE OR MISLEADING INFORMATION MAY RESULT IN MY DISMISSAL AND I AUTHORISE REPRESENTATIVES OF BEST OF CARE PTY LTD TO MAKE ANY ENQUIRIES NECESSARY TO VERIFY THE TRUTH.

Signed: Date:.....