

NOTE: Information disclosed herein in relation to **convictions for any criminal offences** will not preclude any applicant from equal consideration.

Have you ever been convicted of any criminal offence?

No Yes If yes, give

details: _____

Do you suffer or have you ever suffered any of the following?

Heart disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Strains/sprains/dislocations	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Back/neck/ pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Skin Cancers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain in Joints	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hearing Impairment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Problem Vision	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Operation/surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Work related injuries/illness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Major illness Accident	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bad headaches/migraines	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Convulsions/fits	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Trouble with eye sight blurred	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Palpitations	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Breathlessness on walking	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthma/bronchitis/lung problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Frequent coughing	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Wheeze/cough from dust	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Arthritis/Rheumatism	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Neck injury/whiplash	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lower back pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sciatica stiffness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tennis Elbow	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Joint injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Weakness in arms/legs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pain in shoulder/hip/knee/ankle	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Nervous condition	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fracture/dislocated/broken bones	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fits/seizures/epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fainting/Dizziness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hearing Loss	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Poor eyesight/loss of eyesight	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thyroid problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer/ Tumour	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hay fever/ Sinusitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Skin rashes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Eczema/Dermatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
None of the above	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

If yes to any of the above, give details:

Have you ever Injured your:

Neck	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Shoulder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Arm	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Elbow	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Back	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Hips	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Knee	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Ankle	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Ribs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____

Have you ever had;

Back Pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Back Stiffness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Neck pain/stiffness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____

Ringing in your ears Yes No _____
 Ear disease/discharge Yes No _____
 Perforated Eardrum Yes No _____
 Deafness Yes No _____
 Worked in a noisy place Yes No _____
 Hearing Test (if so results?) Yes No _____

Have you had any other serious illness/disease or been in hospital in the past five (5) years?

No Yes If yes, give details _____

List all the time off work for illness or injury in the last eighteen months;

Do you use any narcotics/ stimulants Yes No

Have you ever received or are you currently receiving workers' compensation or made a claim for a work related injury?

No Yes If yes, give the following details _____

Date of Injury/Claim	Nature of Injury/Claim	Name of Employer
/ /	_____	_____
/ /	_____	_____

Are you aware of any physical handicaps or disabilities which would prevent you from performing specific kinds of work for the function you are applying for, or for any other functions?

No Yes If yes, describe the handicap or disability and the resultant work limitations.

Are you prepared to undergo a paid medical examination prior to being offered employment?

Yes No

I hereby declare that my answers supplied to the questions on this application are, to the best of my knowledge and belief, true and correct.

I understand and agree that the employment offered is based upon the accuracy of information contained herein and any misrepresentation of facts or material omission could be cause for dismissal.

I hereby agree that the company may approach/contact any previous employer and/or any referee shown on this application.

Signature of Applicant _____ Date / /

Signature of BRG Representative _____

Senior Managers Approval (signature) _____

Date _____