



Please complete all sections of this form and forward as per application instructions with a copy of your current CV

POSITION SOUGHT

Position Title:

Department:

Employment Status:

Full time Part time Casual
 Temporary Permanent

How did you find out about this position:

Mercy website Internet Newspaper
 Word of Mouth Internal advertisement Other _____

PERSONAL DETAILS

Surname:

Given Name:

Preferred Name:

Address:

Suburb: _____ **Postcode:** _____

Telephone (home):

Telephone (mobile):

Email address:

ELIGIBILITY TO WORK IN AUSTRALIA

Are you an Australian citizen?

Yes No

If NO, have you been granted Permanent Residency?

Yes No

If NO, have you been granted a temporary Visa / Working Permit?

Yes No

If YES, please provide Visa details:

These details are used to verify the currency and work eligibility under the visa

Type:
Visa Number:
Passport Number:
Valid From:
Valid To:

HEALTH ASSESSMENT

Mercy Hospital is an Equal Employment Opportunity employer, and therefore a medical condition, disability or previous Workers Compensation claim is not a barrier to the potential offer of employment.

To assist us in assessing opportunities, please provide details of any previous or current medical condition or restriction, physical or otherwise, which may affect your ability to perform the inherent and essential requirements of the role. Offers of employment are conditional upon you being assessed as being fit to safely undertake the duties of the proposed position without placing yourself or others at a risk of injury.

This must include any medical condition or restriction arising from a previous workers' compensation claim. Failure to provide such information may jeopardise your rights to workers' compensation if a pre-existing disability is aggravated at work (Section 79 of the Workers' Compensation and Rehabilitation Act 1981).

Please select from the following list any illnesses, injuries or disabilities which you have, or are currently suffering:

Visual problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whiplash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty hearing or with balance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia or abdominal ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back /neck trouble or pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood or body fluid borne disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Injury of any kind	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart trouble or experienced chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone fractures or dislocations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures/fits, fainting or dizzy spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Knee trouble/pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychological or psychiatric problems i.e. anxiety, depression, stress, panic attacks etc	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ankle trouble/pain	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Foot / toe trouble/ pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	RSI, Overuse Syndrome or Carpal Tunnel Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin rashes/problems, eczema, dermatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath, asthma, wheeze or suffer from breathing difficulties	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shoulder/elbow or wrist trouble/pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hand/ finger trouble /pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immunosuppressed including receiving chemotherapy or long term steroid use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies or sinusitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug or alcohol addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Health effects from contact with chemicals	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Exposure to noise in previous employment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic joint injury including stiffness or pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tendency to bruise or bleed excessively	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatics or arthritis of any kind	<input type="checkbox"/> Yes <input type="checkbox"/> No
Persistent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle, tendon or ligament problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sporting, vehicle, work related illness or injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Discharged or resigned from a job due to medical reasons	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you selected any of the above please provide details including treatment obtained and current state of injury or illness:

Are there any duties of the position you have applied for which you are, or may be, unable to do due to health problems or physical disability?

Yes No

If yes, please give details:

Have you ever been a patient or worked in a hospital outside Western Australia or overseas in the last twelve months? If yes, please give details:

Yes No

IMMUNISATION/SCREENING FORM

It is a requirement of employment at Mercy Hospital Mount Lawley that all *healthcare employees* who work in clinical areas or have a risk of exposure to bodily fluids or infectious agents in the workplace including clinical staff, Patient Care Assistants, Sterilisation and Housekeeping staff have a pre-employment assessment which includes a review of their immunisation status to ensure that it is current and appropriate for their category of employment.

Please complete the **section below**. All details must be completed and returned with application to enable an informed decision to be made when reviewing your status and making any recommendations. In addition, please provide **proof of evidence of immunity** if you have these documents. If you do not have these documents you will be required to have blood tests to check immunity prior to an offer of employment. Please note that if you are tested and do not have immunity, immunisations will be provided to you.

Methicillin Resistant Staphylococcus Aureus (MRSA) – All Healthcare employees who have worked in or have been hospitalised in a health care facility outside WA or who have worked in a residential care facility within WA in the past 12 months will require MRSA screening **prior** to commencement of employment.

Mantoux – All nursing/medical health care employees and some Patient Care Assistants are required to provide baseline Mantoux results. If you have never had a baseline Mantoux before or do not have evidence please contact the Infection Control Manager on 0427704877 or attend the Anita Clayton Centre for testing. They can be contacted on 92228500.

If you have any concerns in relation to your immunisation/screening requirements please contact the Infection Control Manager at Mercy Hospital on 0427704877

Have you had the following immunisation:

Diphtheria	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Tetanus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Mumps (please provide proof of immunity)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Varicella (Chicken Pox)(please provide proof of immunity)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Rubella (German Measles)(please provide proof of immunity)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Measles (please provide proof of immunity)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
If born after 1966 have you received a measles booster?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Adult Pertussis (Whooping Cough) booster?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Hepatitis B:			
Have you completed a full course of 3 injections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Did you develop immunity post vaccination (please provide proof of immunity)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
MRSA (if yes to either, MRSA screening is required)			
Have you worked in or been a patient in a hospital outside WA during the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you worked in a Residential Care facility in WA during the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Tuberculosis Risk Assessment	
Have you ever had a BCG (Vaccination against TB)? When? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had contact, personally or at work with somebody that has had TB?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a Mantoux skin test (please provide results)? When? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a history of immune deficiency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you Aboriginal or a Torres Strait Islander?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Country of birth _____	

Cleared for employment Signature: _____ Infection Control Manager	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, but follow-up required (Outside WA and overseas applicants) _____
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APPLICATION DECLARATION

I declare the above information to be true in all aspects
I acknowledge that any statement which I have made which is found to be false or deliberately misleading will make me, if employed, liable for dismissal.

I understand that part of the application procedure may involve a medical examination by a medical officer nominated by Mercy Hospital and I authorise disclosure of the results of this examination to Mercy Hospital.

Name:

Signed: **Date:**

Please attach the following as part of your application:

(note: failure to provide complete documentation will result in a delay in progressing your application)

All Applicants:

- Copy of WWC Card (where applicable)
- Copy of National Police Clearance

Nursing/Allied Health and others as requested

- Copy of qualifications
- Copy of AHPRA registration (nursing, allied health)
- Proof of immunity and Mantoux test documents

Privacy: Your application form contains personal information, which will be dealt with in accordance with our Privacy Policy. If you are successful in your application your form will become an employment record. If you are unsuccessful your application form will be kept for 3 months before being destroyed.

OFFICE USE ONLY

- Application details verified and confirmed as complete**
- Acknowledgement letter sent (date):** Date: _____
- Interview date/time:** _____
- Outcome:** _____ **Applicant notified (date):** _____