

Employment Application Form

We are an Equal Opportunities Employer and we welcome applicants regardless of age, religious belief, political opinion, race, gender, sexual orientation, marital status or disability.

PLEASE READ THE WHOLE OF THE FORM BEFORE YOU START FILLING IT IN AND THEN COMPLETE EVERY SECTION.

POSITION APPLIED FOR			JOB REFERENCE			
TITLE	MR/ MRS/ MS/ MISS Please circle as appropriate	NATIONAL INSURANCE NO.				
SURNAME		FORENAME				
ADDRESS						
TOWN/CITY		POSTCODE				
TELEPHONE NUMBER		EMAIL ADDRESS				

Please post the completed form to

Human Resources
SelfBuild Ireland Ltd.

119 Cahard Road
Saintfield

BALLYNAHINCH

BT24 7LA

info@selfbuild.ie

EMPLOYMENT HISTORY - PRESENT

NAME OF EMPLOYER		DATES FROM - TO	
ADDRESS		TITLE OF POST	
		SALARY	
		PERIOD OF NOTICE	
DESCRIPTION OF DUTIES AND RESPONSIBILITIES:			
REASON FOR LEAVING			

NAME & ADDRESS OF EMPLOYER	FROM	TO	JOB TITLE AND DESCRIPTION	REASON FOR LEAVING AND FINISHING SALARY

<p>Have you applied to join this company before? If yes, please give details below</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>Are you subject to restraints on your current or future employment? If yes, please provide details.</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>Do you smoke?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>Do you hold a current Driving Licence?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>Do you have any driving convictions, endorsements or penalty points? If yes please provide details</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>Have you ever been convicted of a criminal offence? You do not need to answer YES if the conviction is spent in accordance with current Rehabilitation of Offenders legislation. But if your answer is YES please give details below.</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>You may use this section to add further information on previous employment or any other experience which you believe might support your application.</p>		

DECLARATION

I certify that all the information I have given is correct. I understand that any false information may result in any job offer being withdrawn.

Signature of applicant _____ Date _____

MEDICAL QUESTIONNAIRE

POSITION				JOB REF		
SURNAME		FORENAME				
ADDRESS						
TOWN/ CITY		COUNTY		POST CODE		
DOCTORS NAME AND FULL POSTAL ADDRESS						

Please complete the following questions ticking the appropriate box. If the answer is yes to any question please give details of (1) Date; (2) Amount of time lost at work; (3) Any treatment at present or planned for the future complete the questionnaire as fully as possible and continue on a separate sheet if necessary. The information will be treated in confidence if information is withheld, suppressed or is deliberately misleading or false you may be liable for dismissal.

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS, IN THE LAST 12 MONTHS			PREVIOUS TO THE LAST 12 MONTHS (SINCE BIRTH)	
1. FAINTING ATTACKS OR GIDDINESS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. BLACKOUTS, EPILEPSY OR FITS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. BRONCHITIS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
ASTHMA	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
PNEUMONIA	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. DERMATITIS, HAND ECZEMA OR OTHER SKIN DISORDERS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. HEART TROUBLE, HEART ATTACK OR ANGINA	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. HIGH BLOOD PRESSURE	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. BACK, NECK OR ANY JOINT PROBLEMS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. NERVOUS DISORDERS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. ANY FORM OF DIABETES	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10 SINUSITIS, DISCHARGING EARS OR HEARING DIFFICULTIES	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11. ANY ALLERGIES:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
PENICILLIN/ ANTIBIOTICS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
HAYFEVER	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
OTHER (please specify)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12. ARE YOU COLOUR BLIND	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13. ARE YOU CURRENTLY, OR HAVE YOU BEEN TAKING TABLETS/MEDICINES OR DRUGS? IF SO, WHAT FOR?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

DECLARATION

I certify that all the information I have given is correct. I understand the warning given above and appreciate that a health interview may be necessary.

Signature _____

Date _____

