



Add: Level 6, HWT Towers
40 City Road, Southbank
Melbourne, VIC 3006
t: +61 (03) 9021 0122
w: www.GreenstaffMedical.com.au

GREENSTAFF MEDICAL APPLICATION FORM

Full Name (As per AHPRA)	<input type="text"/>	Date of Birth	<input type="text"/>			
Phone No.	<input type="text"/>	Email	<input type="text"/>			
Address	<input type="text"/>					
State	<input type="text"/>	Post Code	<input type="text"/>			
Nursing Role	RN <input type="checkbox"/>	RM <input type="checkbox"/>	EEN <input type="checkbox"/>	PCA/AIN <input type="checkbox"/>	Others, please specify <input type="checkbox"/>	<input type="text"/>
Qualification	Bachelor of Nursing <input type="checkbox"/>	Diploma of Nursing <input type="checkbox"/>	Cert III/IV <input type="checkbox"/>	Post Grad Qualification, if Yes, please specify: <input type="text"/>		
Current AHPRA (RN/ RM/ EEN)	<input type="text"/>					
Working Rights in Australia	Australian Citizen <input type="checkbox"/>	Permanent Resident <input type="checkbox"/>	Other visa, please specify <input type="checkbox"/>	<input type="text"/>		
	(Note: Student visa needs to provide COE)					
WWCC Number (Employee)	<input type="text"/>	Note: Children Check (Employee) for VIC, NSW and WA Blue Card (Employee) for QLD				
Uniform Size	<input type="text"/>					

INFORMATION FOR PAYROLL

Banking Details	Account Name	<input type="text"/>	Bank Name	<input type="text"/>
	BSB (6 Digit)	<input type="text"/>	Account Number	<input type="text"/>
Superannuation Details	Account Name	<input type="text"/>	Fund Name	<input type="text"/>
	Membership No.	<input type="text"/>	TFN Number	<input type="text"/>

EMERGENCY CONTACT

Next of Kin details	Name	<input type="text"/>	Relationship	<input type="text"/>
	Phone	<input type="text"/>	Address	<input type="text"/>

PROFESSIONAL/ CLINICAL REFERENCE (Need to be within last 2 years)

Reference 1	Full Name	<input type="text"/>	Position	<input type="text"/>
	Facility Name	<input type="text"/>	Phone/ Official email (no personal)	<input type="text"/>
Reference 2	Full Name	<input type="text"/>	Position	<input type="text"/>
	Facility Name	<input type="text"/>	Phone/ Official email (no personal)	<input type="text"/>

Would you refer other experienced nurses to join Greenstaff Medical?

Referral Details	Full Name	<input type="text"/>	Nursing Role	<input type="text"/>
	Phone	<input type="text"/>	Area of work	<input type="text"/>
Referral Details	Full Name	<input type="text"/>	Nursing Role	<input type="text"/>
	Phone	<input type="text"/>	Area of work	<input type="text"/>

Worker's Compensation and Injury Management Act 1981- Section 79

1. In hospitals and facilities, the role requires physical activity like walking, pushing, pulling, crouching, standing for long periods as well as repetitive movements. Are you aware of any medical condition(s) which may interfere with your ability to perform the inherent requirements of the Position? If yes, please provide details.

2. Have you had any work cover claims in the past? If yes, please explain below.

Work Cover Legislation requires that all persons need to ensure they take reasonable care for his/her own health and safety and for the health and safety of anyone else who may be affected by his/her acts or omissions at the workplace.

Pre-Employment Health Declaration

1. Are you aware of any circumstances regarding your health that would interfere with your ability to perform the inherent requirements of the Position?

In answering this question, regard must be given to any pre-existing injuries or diseases and any medication currently being taken or any treatment currently being received on a regular basis.

No

Yes (If Yes, please provide the details)

2. Are you aware of any existing or pre-existing injury or diseases that could be affected by the inherent requirements of the Position?

In answering this question, regard must be given to any pre-existing injuries or diseases for which you have received, or are receiving, treatment.

No

Yes (If Yes, please provide the details)

3. Are there any other comments you wish to make regarding your health and any effect it may have on the performance of the Position?

No

Yes (If Yes, please provide the details)

4. Do you require any adjustments to enable you to perform the inherent requirements of the Position?

No

Yes (If Yes, please provide the details)

I am aware that failing to complete the Pre-Employment Health Declaration, or disclosing false or misleading information on the Pre-Employment Health Declaration, may result in no offer of employment or, if my employment has commenced, disciplinary action including the possible termination of employment and/or disentitlement to compensation pursuant to the Workplace Injury Rehabilitation and Compensation Act 2013

I have read and accept Greenstaff Medical Terms and Code of Conduct - Greenstaff Terms and Code of conduct.pdf

I have read and accept Greenstaff Medical Pre employment declaration information and position description - Greenstaff Pre employment Information and Position description.pdf

I declare that the information given in this form is correct to the best of my knowledge. I understand that any false or misleading information can lead to termination of my employment with Greenstaff Medical. I understand that I have answered the medical questions fully and understand that any Insurance claims that may result from any conditions I have and have not informed you of may be void. I hereby give my authorization to Greenstaff Medical P/L to use the supplied information in this form, and to contact my referees to further consider my suitability for employment by Greenstaff Medical P/L.

Signature of Applicant: Date: