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## CONFIDENTIAL

# APPLICATION FOR EMPLOYMENT

THIS APPLICATION WILL LAPSE AFTER 12 MONTHS AND MUST BE RENEWED IF YOU WISH TO REMAIN ON OUR RECORDS,

THE RELEVANT INFORMATION THAT YOU PROVIDE WILL BE USED TO ASSESS YOUR SUITABILITY FOR INTERVIEW. IT IS THEREFORE IN YOUR INTEREST TO COMPLETE THIS FORM ACCURATELY AND TO CONSIDER YOUR ANSWERS CAREFULLY BEFORE WRITING THEM DOWN.

APPLICATIONS ARE INVITED FROM PERSONS REGARDLESS OF SEX, RACE, ETHNIC BACKGROUND OR PHYSICAL IMPAIRMENT.

PERSONAL DETAILS	
PREFIX	DR MRS MR MISS MS
SURNAME	
FIRST NAMES	
FORMER NAME (IF APPLICABLE)	
POSTAL ADDRESS	_____ _____ POST CODE _____
EMAIL ADDRESS	
DATE OF BIRTH	
TELEPHONE	HOME _____ MOBILE _____
ARE YOU A PERMANENT AUSTRALIAN CITIZEN?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IF NOT PLEASE IDENTIFY VISA TYPE AND EXPIRY DATE	

HOW DID YOU BECOME AWARE OF THE OPPORTUNITY FOR EMPLOYMENT AT LEVEDA?	
HAVE YOU APPLIED TO LEVEDA BEFORE?	<input type="checkbox"/> YES <input type="checkbox"/> NO

PRE-EMPLOYMENT CRITERIA	
<b>DO YOU HAVE THE FOLLOWING? (IF YES, PLEASE ATTACH A COPY)</b>	
• A POLICE CLEARANCE OBTAINED IN THE LAST 3 MONTHS (ESSENTIAL)	<input type="checkbox"/> YES <input type="checkbox"/> NO
• A CURRENT SOUTH AUSTRALIAN DRIVER'S LICENCE (ESSENTIAL)	<input type="checkbox"/> YES <input type="checkbox"/> NO
• SENIOR FIRST AID CERTIFICATE (ESSENTIAL)	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>OTHER CRITERIA</b>	
• MANUAL HANDLING CERTIFICATE	
• BIRTH CERTIFICATE / PASSPORT	
• MEDICAL	

PREVIOUS EXPERIENCE	
HAVE YOU HAD PREVIOUS EXPERIENCE WORKING WITH PEOPLE WITH A DISABILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO

IF **YES** PLEASE INDICATE THE NATURE OF THIS EXPERIENCE BY TICKING THE BOX USING THE 4 CODES LISTED BELOW.

<b>PAID EMPLOYMENT (PE)</b>	<b>VOLUNTARY (V)</b>	<b>WORK EXPERIENCE (WE)</b>		<b>PERSONAL / FAMILY (P / F)</b>	
<b>PREVIOUS EXPERIENCE</b>		<b>PE</b>	<b>V</b>	<b>WE</b>	<b>P/F</b>
AGED CARE					
YOUTH WORK					
AUTISM					
CHALLENGING BEHAVIOUR					
HEARING IMPAIRMENT					
INTELLECTUAL DISABILITY					
MENTAL HEALTH					
NEUROLOGICAL DISABILITY					
PHYSICAL DISABILITY					
VISION IMPAIRMENT					
ACQUIRED BRAIN INJURY					
ANY OTHER DISABILITY (PLEASE SPECIFY)					

### TRAINING / COURSES / QUALIFICATIONS

<b>NAME OF COURSE</b>	<b>DATE COMPLETED</b>	<b>STILL STUDYING</b>	<b>DID NOT COMPLETE</b>
SENIOR FIRST AID CERTIFICATE		<input type="checkbox"/>	<input type="checkbox"/>
CARERS' PRE-EMPLOYMENT TRAINING COURSE		<input type="checkbox"/>	<input type="checkbox"/>
CERTIFICATE II COMMUNITY SERVICES (DISABILITY)		<input type="checkbox"/>	<input type="checkbox"/>
CERTIFICATE II COMMUNITY SERVICES (AGED CARE)		<input type="checkbox"/>	<input type="checkbox"/>
CERTIFICATE III COMMUNITY SERVICES (DISABILITY)		<input type="checkbox"/>	<input type="checkbox"/>
CERTIFICATE III COMMUNITY SERVICES (AGED CARE)		<input type="checkbox"/>	<input type="checkbox"/>
CERTIFICATE IV COMMUNITY SERVICES (DISABILITY)		<input type="checkbox"/>	<input type="checkbox"/>
CERTIFICATE IV COMMUNITY SERVICES (AGED CARE)		<input type="checkbox"/>	<input type="checkbox"/>
MANUAL HANDLING CERTIFICATE		<input type="checkbox"/>	<input type="checkbox"/>
BACHELOR OF DISABILITY STUDIES		<input type="checkbox"/>	<input type="checkbox"/>
BACHELOR OF SPECIAL EDUCATION		<input type="checkbox"/>	<input type="checkbox"/>
MANDATED NOTIFICATION TRAINING		<input type="checkbox"/>	<input type="checkbox"/>
OTHER STUDY (PLEASE INDICATE)			
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

### OTHER SKILLS

PLEASE INDICATE IF YOU HAVE HAD ANY EXPERIENCE IN THE FOLLOWING AREAS:

WORD PROCESSING	<input type="checkbox"/> YES <input type="checkbox"/> NO	SPREADSHEET	<input type="checkbox"/> YES <input type="checkbox"/> NO
INTERNET	<input type="checkbox"/> YES <input type="checkbox"/> NO	E-MAIL	<input type="checkbox"/> YES <input type="checkbox"/> NO
PLEASE INDICATE IF YOU HAVE ANY OTHER PERSONAL SKILLS OR EXPERIENCE THAT YOU THINK COULD BE RELEVANT TO THE POSITION.			

**EMPLOYMENT HISTORY**

PLEASE LIST YOUR DETAILS STARTING WITH YOUR MOST RECENT/CURRENT EMPLOYER.  
 THIS INFORMATION WILL BE KEPT CONFIDENTIAL.  
 PLEASE FEEL FREE TO ELABORATE FURTHER ON ANOTHER SHEET IF NECESSARY.

<b>MAY WE CONTACT THIS EMPLOYER FOR A REFERENCE?</b>			<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>1.</b>	DATE:	FROM _____, _____ MONTH                      YEAR	TO _____, _____ MONTH                      YEAR
EMPLOYER: _____		ADDRESS: _____	
POSITION: _____		_____	
NATURE OF WORK OR DUTIES PERFORMED:			
_____			
_____			
FULL-TIME OR PART-TIME: _____			
REASON FOR LEAVING: _____			

<b>MAY WE CONTACT THIS EMPLOYER FOR A REFERENCE?</b>			<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>2.</b>	DATE:	FROM _____, _____ MONTH                      YEAR	TO _____, _____ MONTH                      YEAR
EMPLOYER: _____		ADDRESS: _____	
POSITION: _____		_____	
NATURE OF WORK OR DUTIES PERFORMED:			
_____			
_____			
FULL-TIME OR PART-TIME: _____			
REASON FOR LEAVING: _____			

**REFEREES**

PLEASE PROVIDE DETAILS OF THREE WORK RELATED REFEREES.

- 1. NAME: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_
- 2. NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_
- 3. NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

**MEDICAL HISTORY**

- 1. THE REQUIREMENTS OF THE POSITION NECESSITATE THE EMPLOYEE TO BE ABLE TO PERFORM FREQUENT AND REPETITIVE MANUAL HANDLING TASKS. APPLICANTS WILL BE REQUIRED TO LIFT IN EXCESS OF (16KG), TURN BEND ON A FREQUENT BASIS. IS THERE ANYTHING IN YOUR MEDICAL HISTORY THAT WOULD PREVENT YOU FROM MEETING THIS REQUIREMENT?  
 YES  NO
- 2. STAFF ARE REQUIRED TO HAVE AN ABILITY TO WORK UNDER PRESSURE, MEETING TIME LINES AND OFTEN DEALING WITH A DIFFICULT CLIENT BASE, IS THERE ANYTHING IN YOUR MEDICAL HISTORY THAT WOULD PREVENT YOU FROM MEETING THIS REQUIREMENT?  
 YES  NO

IF YES TO ANY OF THE TWO QUESTIONS ABOVE, GIVE DETAILS:

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IMPORTANT: FAILURE TO DISCLOSE A PRE-EXISTING MEDICAL CONDITION MAKES MANAGEMENT'S RESPONSIBILITY TO PROVIDE A SAFE PLACE OF WORK UNDER SECTION 19 OF THE OCCUPATIONAL HEALTH SAFETY & WELFARE ACT EXTREMELY DIFFICULT AND MAY RESULT IN IMMEDIATE DISMISSAL UPON DISCOVERY.

- WILL YOU AGREE TO UNDERGO A MEDICAL EXAMINATION, IF REQUESTED?  YES  NO
- HEALTH: TO THE BEST OF YOUR KNOWLEDGE AND BELIEF ARE YOU OF SOUND HEALTH?  YES  NO

(APPLICANTS WHO HAVE A DISABILITY ARE INVITED TO DISCUSS WITH US THE RELEVANCE OR OTHERWISE TO THE EMPLOYMENT APPLIED FOR).

**CONVICTIONS:** ONLY PERSONS OVER THE AGE OF 18 YEARS ARE OBLIGED TO COMPLETE THIS SECTION.

HAVE YOU BEEN CONVICTED OF A CRIMINAL OFFENCE? YES / NO

IF YES PLEASE PROVIDE BRIEF DETAILS:

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## **ROSTER PREFERENCE APPLICATION**

**Name:**.....

Please ensure you have nominated your availability- **BY TICKING THE APPROPRIATE BOX**

**'ROSTER PERIOD ONLY'**     **'ONGOING UNTIL FURTHER NOTICE'**   

PLEASE NOTE:

- Should your availability change please notify the Leveda Office A.S.A.P
- Should you be unable to undertake any allocated shifts please notify the Leveda Office A.S.A.P
- Forms may be returned by either post/fax or email.
- Shifts will be allocated based on preferences and availability of work

**Please indicate your availability as follows:**

X	NOT AVAILABLE
✓	AVAILABLE ALL HOURS
0900-1400.	AVAILABLE BETWEEN CERTAIN TIMES ONLY.

	<i>TUESDAY</i>	<i>WEDNESDAY</i>	<i>THURSDAY</i>	<i>FRIDAY</i>	<i>SATURDAY</i>	<i>SUNDAY</i>	<i>MONDAY</i>
AM							
PM							
	<i>TUESDAY</i>	<i>WEDNESDAY</i>	<i>THURSDAY</i>	<i>FRIDAY</i>	<i>SATURDAY</i>	<i>SUNDAY</i>	<i>MONDAY</i>
	<i>TUESDAY</i>	<i>WEDNESDAY</i>	<i>THURSDAY</i>	<i>FRIDAY</i>	<i>SATURDAY</i>	<i>SUNDAY</i>	<i>MONDAY</i>
	<i>TUESDAY</i>	<i>WEDNESDAY</i>	<i>THURSDAY</i>	<i>FRIDAY</i>	<i>SATURDAY</i>	<i>SUNDAY</i>	<i>MONDAY</i>
	<i>TUESDAY</i>	<i>WEDNESDAY</i>	<i>THURSDAY</i>	<i>FRIDAY</i>	<i>SATURDAY</i>	<i>SUNDAY</i>	<i>MONDAY</i>

## COMMUNITY SUPPORT WORKER APPLICATION PROCESS CHECK LIST

PLEASE COMPLETE THE FOLLOWING CHECK LIST TO ENSURE THAT YOU HAVE COMPLETED ALL COMPONENTS OF THE APPLICATION PROCESS.

TO BE CONSIDERED FOR A POSITION AT LEVEDA, YOU MUST DO THE FOLLOWING:

COMPLETE AN APPLICATION FORM	
PROVIDE CONTACT DETAILS FOR 2 REFEREES WHO ARE ABLE TO SPEAK ON YOUR SUITABILITY TO WORK AS A COMMUNITY SUPPORT WORKER (NOT FAMILY OR FRIENDS)	
ATTACH A COPY OF YOUR DRIVER'S LICENCE (FRONT AND BACK)	
ATTACH A COPY OF YOUR SENIOR FIRST AID CERTIFICATE (ISSUED WITHIN 3 YEARS)	
ATTACH A COPY OF YOUR POLICE CLEARANCE (ISSUED WITHIN THE PAST 3 MONTHS)	
ATTACH A COPY OF YOUR MANUAL HANDLING CERTIFICATE (ISSUED WITHIN THE PAST 12 MONTHS)	
ATTACH A COPY OF YOUR CERTIFICATE III IN COMMUNITY SERVICES (DISABILITY / AGED CARE)	
<b>IF YOU'RE NOT AN AUSTRALIAN CITIZEN, ATTACH A COPY OF YOUR WORKING VISA</b>	

## PRIVACY

### (IN ACCORDANCE WITH NATIONAL PRIVACY PRINCIPLES 1.3 & 1.5)

THE PROCESS USED TO ASSESS YOUR SUITABILITY AS A COMMUNITY SUPPORT WORKER FOR LEVEDA REQUIRES YOU TO COMPLETE THIS STANDARD APPLICATION FORM. WE REQUIRE SOME PERSONAL DETAILS SUCH AS YOUR NAME, HOME ADDRESS, TELEPHONE NUMBERS, INFORMATION ABOUT YOUR PAST EMPLOYERS AND TWO NOMINATED REFEREES.

WE REQUIRE THIS INFORMATION SO THAT:

- WE CAN CONTACT YOUR REFEREES TO VERIFY YOUR PAST WORK EXPERIENCE;
- WE CAN CONTACT YOU TO ADVISE YOU WHETHER YOUR APPLICATION HAS BEEN SUCCESSFUL OR NOT;
- SHOULD YOU BE SUCCESSFUL YOUR DETAILS CAN BE ENTERED INTO OUR COMPUTERISED HUMAN RESOURCES INFORMATION SYSTEM FOR THE EFFECTIVE ADMINISTRATION OF PAYROLL AND MANDATORY TRAINING.'

IT IS LEVEDA'S POLICY TO CHECK THE VISA STATUS OF NON-PERMANENT AUSTRALIAN RESIDENTS AND NON-AUSTRALIAN CITIZENS WITH THE DEPARTMENT OF IMMIGRATION.

THE PERSONAL INFORMATION THAT WE COLLECT IS ACCESSED BY ONLY RELEVANT STAFF MEMBERS IN THE PERFORMANCE OF THEIR DUTIES. THE INFORMATION IS HELD IN CONFIDENCE BY LEVEDA EXCEPT WHERE THE RELEASE OF SUCH INFORMATION IS REQUIRED BY LAW.

NONE OF THE INFORMATION COLLECTED IS USED FOR ANY PURPOSE OTHER THAN THOSE OUTLINED ABOVE. NO INFORMATION IS DISCLOSED TO OTHER ORGANISATIONS OR PERSONS OUTSIDE LEVEDA EXCEPT WITH THE WRITTEN PERMISSION OF THE APPLICANT.

