

AUSTRALIAN CARE PROVIDERS -ABN: 52 131 343 470

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Email: support@australiacareproviders.com



JOB APPLICATION FORM

DATE: _____

SURNAME: _____ **GIVEN NAME:** _____

ADDRESS: _____

PHONE NO (H): _____ **MOBILE NO:** _____

EMAIL: _____ **DATE OF BIRTH:** _____

QUALIFICATIONS AND SKILLS (EG. Do you have a First Aid Certificate?):

PREFERRED WORK AREAS (Aged/Disability/Palliative/Children/Mental Illness):

Do you have any physical or psychological limitations which may restrict you working in the role of Support Worker – Aged/Disability?

If yes give details: _____

HAVE OWN TRANSPORT: YES/NO

COMPREHENSIVE CAR INSURANCE : YES/NO

Have you ever been involved in any fraudulent matter relating to motor vehicles? Y/N

Have you ever had a Driver's Licence revoked or suspended? Y/N

Have you ever had a driving offence or motor vehicle accident? Y/N

If yes give details: _____

PREFERRED TOWNS/AREAS TO WORK IN: _____

REFEREES (Name, Job Title & Contact Details):

I _____ **declare that the information I have given above to be true and correct.**
(Full name)

Signature _____ **Dated** _____

*Please include a current resume with this application. ** Note: You will be required to obtain a Federal Police Check & a Working With Children's Check before commencing employment with us, if you have either/both of these from a recent employer, please include them with this application*