

# HEHIR'S TRANSPORT

PTY LTD ABN: 30 060 804 159  
PO BOX 8025 RAND 2642  
PH: 02 6029 5234 FAX: 02 6029 5300



## DRIVER EMPLOYMENT APPLICATION

It is our policy to consider all applicants for a position without regard to race, colour, religion, sex, national origin, age, marital status, or non-job related disability. In the event of employment, I understand that false or misleading information given in this form, interviews, medical or other employment processes may result in dismissal.

### GENERAL

SURNAME: \_\_\_\_\_ GIVEN NAMES: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
CURRENT ADDRESS: \_\_\_\_\_ STATE: \_\_\_\_\_ POST CODE: \_\_\_\_\_  
PREVIOUS ADDRESS IF AT ABOVE ADDRESS LESS THAN 12 MONTHS \_\_\_\_\_  
\_\_\_\_\_  
CURRENT PHONE NUMBERS – HOME: \_\_\_\_\_ MOBILE: \_\_\_\_\_  
EMAIL: \_\_\_\_\_  
NEXT OF KIN: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
CONTACT NUMBERS: WORK \_\_\_\_\_ MOBILE: \_\_\_\_\_

### EDUCATION

HIGHEST LEVEL ACHIEVED AT SCHOOL \_\_\_\_\_  
TRADE/QUALIFICATIONS: \_\_\_\_\_

### EMPLOYMENT HISTORY – LIST LAST 5 EMPLOYERS IN ORDER OF LAST EMPLOYER NO 1.

EMPLOYER NAME	LOCATION	PHONE NO.	POSITION HELD EG. DRIVER	PERIOD OF EMPLOYMENT	REASON FOR LEAVING
1					
2					
3					
4					
5					

VEHICLE TYPE EG. RIGID, SEMI, BDOUBLE	TYPE OF WORK EG. TIPPER, GENERAL, FRIDGE	NO. OF YEARS EXPERIENCE	WHEN EXPERIENCE GAINED EG. 1980-1990	EMPLOYER

Are you currently employed? Y/N If not, how long since leaving last employment? \_\_\_\_\_

**ACCIDENT HISTORY** – LIST ANY VEHICLE ACCIDENTS IN LAST 5 YEARS

DATE (APPROX)	NATURE OF ACCIDENT EG. SINGLE VEHICLE, HEAD ON, ROLLOVER	APPROX DAMAGE TO YOUR VEHICLE \$	WERE YOU AT FAULT (Y/N)	SERIOUS INJURIES/FATALITIES Y/N

**LICENCE & QUALIFICATIONS** – LIST ALL CURRENT LICENCES AND AUTHORISATIONS EG. DRIVERS, DANGEROUS GOODS, FATIGUE, BLUECARD, CERT III, FORKLIFT/PLANT TICKETS

TYPE & CLASS	LICENCE / AUTH NO	STATE OF ISSUE	EXPIRY DATE	YEARS HELD

Have you ever had your driver's licence cancelled or suspended? Y/N \_\_\_\_\_

If yes, provide details \_\_\_\_\_

Are you prepared to sign a letter of authority for this company to obtain your driving history every 12 months from the relevant road authority? Y/N\_\_\_\_\_

Are you a member of Transport Workers Union? Y/N\_\_\_\_\_

Have you ever been charged with an alcohol, drug related or criminal offence? Y/N\_\_\_\_\_

If yes, provide details \_\_\_\_\_

Have you ever had, or do you currently have any pending claims for workers compensation? Y/N\_\_\_\_\_

If yes, provide details \_\_\_\_\_

Are you prepared to sign a letter of authority for this company to obtain your workers compensation history? Y/N\_\_\_\_\_

Do you have any physical, mental or learning disabilities or conditions which the company may need to accommodate? Y/N\_\_\_\_\_

If yes, provide details \_\_\_\_\_

Are you prepared to undergo medical examinations by the company appointed doctor as required? Y/N \_\_\_\_\_

Approximate date of your last commercial drivers medical? \_\_\_\_\_

Do you hold Basic Fatigue Management Certification? Y/N\_\_\_\_\_

If yes, please bring a copy of your certificate for our records.

**DECLARATION**

This certifies that I have completed this application and that all information is true and complete to the best of my knowledge.

I authorise you to make any investigations and enquiries on my personal, medical, employment and other related history as may be necessary in making an employment decision. I hereby release employers, medical and government authorities from all liability in responding to these enquiries.

In the event of employment I understand that false or misleading information given in my employment process may result in termination of employment. I also understand that I am required to abide by all policy, procedures and rules of the company.

I understand that if I am successful in gaining a position with this company that I will be on a probationary period of 3 months during which time my performance will be monitored. If management is not satisfied with such I may be dismissed without prior warning.

NAME OF APPLICANT \_\_\_\_\_ SIGNATURE \_\_\_\_\_

NAME OF WITNESS \_\_\_\_\_ SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**OFFICE USE ONLY**

	Completed Y/N	Comments	Not acceptable	Acceptable	Above average
Application form					
Required licenses					
License printout					
Relevant experience					
Interview					
Past employment					
References checked					
Accident history					
Criminal convictions					
Road test					
Driver profile					
Medical assessment					
Workcover claims					

**Employment Detail**

Start Date: \_\_\_\_\_

Induction Date \_\_\_\_\_

Probation end date: \_\_\_\_\_

**Termination Detail**

Termination date \_\_\_\_\_ Dismissed Quit

Reason \_\_\_\_\_

\_\_\_\_\_

**MEDICAL QUESTIONNAIRE**

**(TO BE COMPLETED BY THE DRIVER)**

Are you currently being treated by a practitioner for any illness or injury? Y/N

Are you taking any prescribed medications? Y/N

Have you ever had an accident as a result of blacking out or falling asleep? Y/N

In the past year have you had to pull off the road because you became sleepy? Y/N

Have you ever been told by your doctor that you have or experienced any of the following:

- |   |     |
|---|-----|
| ▪ High blood pressure                           | Y/N |
| ▪ Heart disease                                 | Y/N |
| ▪ Chest pain or angina                          | Y/N |
| ▪ Require heart surgery                         | Y/N |
| ▪ Palpitations or irregular heart beat          | Y/N |
| ▪ Abnormal shortness of breath                  | Y/N |
| ▪ Head, back or spinal injury                   | Y/N |
| ▪ Seizures, fits or convulsions                 | Y/N |
| ▪ Blackouts or fainting                         | Y/N |
| ▪ Stroke  | Y/N |
| ▪ Dizziness or vertigo                          | Y/N |
| ▪ Double or blurred vision or difficulty seeing | Y/N |
| ▪ Colour blindness                              | Y/N |
| ▪ Psychiatric illness or nervous disorder       | Y/N |
| ▪ Kidney disease                                | Y/N |
| ▪ Diabetes                                      | Y/N |
| ▪ Sleep disorder                                | Y/N |
| ▪ Alcohol abuse                                 | Y/N |
| ▪ Bleeding bowel or black motion                | Y/N |

Have you ever had any serious illness, injury, operation or been in hospital? Y/N

Details \_\_\_\_\_

Have you ever contemplated or attempted suicide? Y/N

Do you smoke? Y/N How many per day? \_\_\_\_\_

Do you drink alcohol on a regular basis? Y/N

How many drinks per week? \_\_\_\_\_ Beer, wine or spirits? \_\_\_\_\_

Do you, or have you used illicit drugs? Y/N

Do you use any drugs to help stay awake whilst driving? Y/N

**DECLARATION**

I certify that to the best of my knowledge the above information is true and complete. I consent to the company appointed doctor releasing medical information to the company in direct relation to my eligibility for a commercial driving position.

Signature \_\_\_\_\_

Date \_\_\_\_\_