

LAURENS PATISSERIES LIMITED
 JESSOP WAY, NEWARK,
 NOTTINGHAMSHIRE
 NG24 2ER TELEPHONE: 01636 613171



**CONFIDENTIAL
 APPLICATION FORM FOR
 EMPLOYMENT**

REF No: PER/0001

PLEASE COMPLETE THIS FORM IN INK & BLOCK CAPITALS AND RETURN TO THE ABOVE ADDRESS

FORENAMES: _____ MR/MRS/MISS SURNAME: _____ MARITAL STATUS: NATIONALITY:	DATE OF BIRTH: / / AGE: MAIDEN NAME: DEPENDENTS AGES: NEXT OF KIN: THEIR ADDRESS POST CODE EMERGENCY CONTACT NAME & NUMBER:
HOME ADDRESS: _____ _____ _____ POST CODE: _____ TELEPHONE NO:	

POSITION APPLIED FOR:

FULL TIME DAYS..... FULL TIME NIGHTS..... PART TIME EVENINGS.....

PLEASE SUPPLY THE FOLLOWING INFORMATION FOR YOUR PROTECTIVE CLOTHING:

SHOE SIZE..... COAT SIZE: SMALL/MEDIUM/LARGE/EXTRA LARGE

SECONDARY EDUCATION (NOT APPLICABLE IF OVER 30 YEARS OF AGE)

<u>DATES</u>	<u>SCHOOL</u>	<u>QUALIFICATIONS</u>
/ / TO / /		
/ / TO / /		

EMPLOYMENT RECORD FOR THE LAST 5 YEARS

<u>DATES</u>	<u>NAME & ADDRESS OF EMPLOYER</u>	<u>POSITION HELD</u>	<u>REASON FOR LEAVING</u>	<u>SALARY</u>

PLEASE SUPPLY THE NAME AND ADDRESS OF TWO REFEREES

NAME _____	NAME _____
ADDRESS _____	ADDRESS _____
_____	_____

FORENAMES

SURNAME
MR/MRS/MISS

ADDRESS

TELEPHONE NUMBER

SEX M/F DATE OF BIRTH

DOCTORS NAME

SURGERY ADDRESS

TELEPHONE NUMBER

NATIONAL INSURANCE NUMBER

SHIFT APPLIED FOR

LAURENS PATISSERIES LIMITED
HEALTH QUESTIONNAIRE

**THE COMPANY WILL HONOUR ITS OBLIGATIONS UNDER THE DISABILITY DISCRIMINATION ACT 1995
AND HEALTH & SAFETY AT WORK LEGISLATION.**

1. THIS INFORMATION IS FOR THE USE OF THE COMPANY PERSONNEL MANAGER. THE FORM WILL BE RETAINED AS PART OF THE COMPANY **CONFIDENTIAL** RECORDS.
2. IN ACCORDANCE WITH LEGAL REQUIREMENTS THE CONTENTS WILL **NOT** BE DISCLOSED WITHOUT YOUR PERMISSION TO ANY UNAUTHORISED PERSONNEL.
3. PLEASE COMPLETE THIS FORM AS ACCURATELY AS POSSIBLE.
4. PLEASE PRINT YOUR ANSWERS OR DELETE AS APPROPRIATE. YOUR ATTENTION IS DRAWN TO THE DECLARATION ON THE LAST PAGE. PLEASE SIGN WHERE INDICATED.
5. THERE IS SPACE PROVIDED FOR FURTHER INFORMATION. IF YOU HAVE ANSWERED **YES** TO ANY QUESTIONS, **YOU MUST USE THIS SPACE TO GIVE DETAILS, INCLUDING DATES.**

PLEASE ANSWER ALL QUESTIONS HONESTLY

DELETE AS APPROPRIATE

- | | | |
|-----|---|--------|
| 1. | <u>DO YOU WEAR CONTACT LENSES OR GLASSES?</u> | YES/NO |
| 2. | <u>DO YOU HAVE POOR EYESIGHT IN EITHER OF YOUR EYES-EVEN WITH GLASSES?</u> | YES/NO |
| 3. | <u>DO YOU HAVE POOR HEARING IN EITHER EAR?</u> | YES/NO |
| 4. | <u>PREVIOUS NOISE EXPOSURE (INCLUDING LEISURE, WORK, HM FORCES)</u> | YES/NO |
| a. | <u>DO YOU SUFFER HEARING LOSS BY DISEASE?</u> | YES/NO |
| b. | <u>HAVE YOU EXPERIENCED REGULAR EXPOSURE TO BLAST/EXPLOSION?</u> | YES/NO |
| c. | <u>DO YOU HAVE REGULARLY USE A RIFLE OR SHOTGUN?</u> | YES/NO |
| d. | <u>DO YOU SUFFER FROM EARACHE OR DISCHARGE FROM YOUR EARS?</u> | YES/NO |
| e. | <u>HAVE YOU HAD AN EAR OPERATION?</u> | YES/NO |
| f. | <u>HAVE YOU A HISTORY OF EAR TRAUMA/INJURY?</u> | YES/NO |
| g. | <u>IS THEIR EAR DISEASE/DEAFNESS IN YOUR FAMILY?</u> | YES/NO |
| h. | <u>DO YOU SUFFER WITH TINNITUS (RINGING IN THE EARS)?</u> | YES/NO |
| i. | <u>DO YOU WEAR A HEARING AID?</u> | YES/NO |
| 5. | <u>IS IT MORE THAN 12 MONTHS SINCE YOU VISITED THE DENTIST?</u> | YES/NO |
| 6. | <u>DO YOU BITE YOUR NAILS?</u> | YES/NO |
| 7. | <u>ARE YOU RECEIVING MEDICAL TREATMENT OR MEDICATION AT PRESENT?</u> | YES/NO |
| 8. | <u>HAVE YOU EVER BEEN AN IN PATIENT IN HOSPITAL?</u> | YES/NO |
| 9. | <u>HAVE YOU EVER BEEN RECOMMENDED TO CONSULT OR CONSULTED A MEDICAL
OR SURGICAL SPECIALIST?</u> | YES/NO |
| 10. | <u>HAVE YOU HAD AN OPERATION OF ANY KIND?</u> | YES/NO |
| 11. | <u>HAVE YOU EVER HAD AN ILLNESS OR INJURY CAUSING YOU TO BE OFF WORK FOR
MORE THAN 2 WEEKS?</u> | YES/NO |
| 12. | <u>HAVE YOU EVER HAD A SEVERE ILLNESS, INJURY OR LONG STANDING CONDITION?</u> | YES/NO |
| 13. | <u>ARE YOU REGISTERED DISABLED OR SUFFER A DISABILITY ?</u> | YES/NO |
| 14. | <u>ARE YOU HIV ANTIBODY POSITIVE OR SUFFER FROM AIDS?</u> | YES/NO |
| 15. | <u>HAVE YOU EVER SUFFERED FROM AN ILLNESS CONNECTED WITH YOUR OCCUPATION?</u> | YES/NO |
| 16. | <u>HAVE YOU EVER SUFFERED FROM A REPETITIVE STRAIN INJURY?</u> | YES/NO |
| 17. | <u>HAVE YOU HAD PROTECTION AGAINST TETANUS? IF YES WHEN WAS YOU'RE LAST BOOSTER?</u> | YES/NO |

18 **HAVE YOU EVER SUFFERED FROM:**

a.	<u>DIZZY SPELLS, BLACKOUTS OR FITS?</u>	YES/NO
b.	<u>STOMACH OR BOWEL PROBLEMS?</u>	YES/NO
c.	<u>RUPTURE/HERNIA?</u>	YES/NO
d.	<u>DIABETES?</u>	YES/NO
e.	<u>RHEUMATIC FEVER?</u>	YES/NO
f.	<u>KIDNEY OR BLADDER DISEASE/URINARY INFECTIONS?</u>	YES/NO
g.	<u>RECURRENT INDIGESTION?</u>	YES/NO
h.	<u>SEVERE SHORTNESS OF BREATH?</u>	YES/NO
i.	<u>BACK TROUBLE/PAINFUL JOINTS/MUSCLE PROBLEMS?</u>	YES/NO
j.	<u>DO YOU HAVE ANY DEFECT, DISORDER, OR OTHER CONDITION MENTAL OR PHYSICAL NOT ALREADY MENTIONED IN ANY OF YOUR ANSWERS?</u>	YES/NO
k.	<u>CHEST TROUBLE-PERSISTENT COUGH/ASTHMA?</u>	YES/NO
l.	<u>HEART TROUBLE OR CONDITION TREATED BY A DOCTOR?</u>	YES/NO
m.	<u>RAISED BLOOD PRESSURE?</u>	YES/NO
n.	<u>DO YOU SMOKE? IF YES APPROXIMATELY HOW MANY CIGARETTES A DAY?</u>	YES/NO
o.	<u>RECURRING HEADACHES OR MIGRAINE?</u>	YES/NO
p.	<u>ALLERGIES: ARE YOU ALLERGIC TO CERTAIN MEDICINE OR FOODS? INCLUDING NUT ALLERGY</u>	YES/NO
q.	<u>NERVOUS DISORDER BREAKDOWN?</u>	YES/NO
r.	<u>DO YOU HAVE A MEDICAL CONDITION, WHICH YOU WISH TO DISCUSS IN CONFIDENCE?</u>	YES/NO

19 **HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS?**

a.	<u>TUBERCULOSIS?</u>	YES/NO
b.	<u>SALMONELLA?</u>	YES/NO
c.	<u>PERSISTENT COUGH?</u>	YES/NO
d.	<u>DIARRHOEA/VOMITING LASTING MORE THAN 24 HOURS IN THE LAST 12 MONTHS?</u>	YES/NO
e.	<u>OTHER RECURRENT INFECTIONS OF THE NOSE, THROAT, MOUTH, EARS OR EYES?</u>	YES/NO
f.	<u>LIVER COMPLAINT OR HEPATITIS?</u>	YES/NO
g.	<u>TYPHOID/PARATYPHOID?</u>	YES/NO
h.	<u>SKIN DISORDERS, ECZEMA, DERMATITIS, PSORIASIS?</u>	YES/NO

PLEASE GIVE FURTHER DETAILS IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS

ANY OTHER INFORMATION RELEVANT TO JOB APPLICATION OR ANYTHING YOU WISH TO DISCUSS FURTHER AT INTERVIEW.

DECLARATION: THE INFORMATION I HAVE GIVEN IN THIS APPLICATION FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE:

SIGNED.....

DECLARATION

I DECLARE THAT THE INFORMATION I HAVE GIVEN IS CORRECT AND I HAVE NO OTHER DEFECT, DISORDER OR OTHER CONDITION, MENTAL OR PHYSICAL, NOT ALREADY MENTIONED.

I UNDERSTAND THAT IF I HAVE SUPPLIED ANY INFORMATION, WHICH IS NOT CORRECT, OR I HAVE FAILED TO MENTION, THEN MY EMPLOYMENT WILL BE TERMINATED FORTHWITH.

SIGNED.....

DATE.....

FOR OFFICE USE ONLY

FIT FOR EMPLOYMENT

FIT FOR EMPLOYMENT, BUT NOT AS A FOOD HANDLER UNTIL FURTHER DETAILS OBTAINED

UNFIT TO START WORK UNTIL FURTHER DETAILS OBTAINED

UNFIT TO WORK AS A FOOD HANDLER

FOR OFFICE USE ONLY

**SHIFT:
RATE**

TRAINING RATE

FULL