



CAREWORKER APPLICATION FORM

NAME: _____

PHONE: _____ MOBILE: _____

ADDRESS: _____

GENERAL PRACTITIONER: _____ DATE OF BIRTH: _____

ETHNIC GROUP: _____ IWI: _____

HAPU: _____

NEXT OF KIN: _____ PHONE: _____

RELATIONSHIP: _____

RELEVANT QUALIFICATIONS AND EXPERIENCE: _____

AVAILABILITY	AM	PM
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

BRIEF HEALTH HISTORY: _____

HAVE YOU ANY ONGOING MEDICAL REQUIREMENTS: YES/NO

IF YES PLEASE DETAIL: _____

DO YOU SMOKE: YES/NO

INLAND REVENUE NUMBER

TAX CODE

COPY OF DRIVERS LICENCE ATTACHED YES/NO Licence Number _____

BANK SLIP ATTACHED YES/NO

PAY SLIP REQUIRED YES/NO MAIL / HOLD

POLICE CHECK: (All prospective employees of the Disabilities Resource Centre Trust are required to complete a police check)

I give my permission for Disabilities Resource Centre Trust to submit a police check and keep this information on their files.

SIGNED: _____ DATE: _____

CHARACTER REFFERENCE: (Please give the names, addresses, and telephone numbers of two people of good standing that we may contact for a reference, preferably including a previous employer).

1. _____

2. _____

I give my permission for Disabilities Resource Centre Trust to keep this information on their files.

SIGNED: _____ DATE: _____

FOR OFFICE USE ONLY	INITIAL CONTACT DATE:
	INTERVIEW DATE:
	REFERENCE CHECK - ONE:
	-TWO:
	ACCEPTED YES/NO:
	NOTIFIED:
	CLIENT CHOICE: