



Employee Information

FULL NAME	
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Mailing			
Address		Post Code:	

PHONE:		MOBILE:		DOB:	
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Next of Kin:		Phone:	
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Medical Assessment Completed		Yes		No
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BANK:		BRANCH:	
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Account Name		BSB:		A/c No:	
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Tax File No:	
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BERT No:		BUSS No:	
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Portable Long Service Leave No:		Start Date:	
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*****Please Note:** Qclad Pty Ltd pays wages directly into your Bank Account via electronic transfer. We are unable to do this with a Building Society . . . Please give us Bank Accounts only.
If you have an ANZ Account the transfer will happen immediately



Employment History

Employment History should cover your last three positions (commencing with your CURRENT status).

Current Employer

Position:

Employed from: to

Phone:

Project or Address of Employer

Supervisor's Name

Reason for leaving

Previous Employer

Position

Employed from: to Phone:

Project or Address of Employer

Supervisor's Name

Reason for leaving

Previous Employer

Position

Employed from: to Phone:

Project or Address of Employer

Supervisor's Name

Reason for leaving



Work Experience and Attainment

apply

General Industry Induction

Work Activity Induction (Safety Handbook)

Site Induction

Delete what doesn't

Yes No

Yes No

Yes No

Tickets/Qualification

1.			Yrs. Experience
2.			Yrs. Experience
3.			Yrs. Experience
4.			Yrs. Experience
5.			Yrs. Experience
6.			Yrs. Experience

Competency Standard

apply

Accident and Hazard Reporting

Roof Work

Personal Fall Protection Procedures

Swing Stage Procedures

Delete what doesn't

Yes No

Yes No

Yes No

Yes No

Any deficiencies in skills and competencies?:

What additional training required?:



Supervisor/Training Officer		Date:	
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Pre-Employment Health Questionnaire

Name:	
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Have you ever had, or are you currently suffering from:

	Yes	No
Musculoskeletal		
Back Trouble	[]	[]
Neck Trouble	[]	[]
Repetitive Strain Injury (RSI)	[]	[]
Knee problems	[]	[]
Other Joint problems	[]	[]
Respiratory		
Asthma	[]	[]
Chronic Bronchitus	[]	[]
Hay Fever/Allergies	[]	[]
Shortness of Breath	[]	[]
Coughing of Blood	[]	[]
Skin		
Dermatitis	[]	[]
Allergies	[]	[]
Melenoma	[]	[]
Internal		
Kidney Problems	[]	[]
Stomach ulcer	[]	[]
Hernia	[]	[]
Chest Pains	[]	[]
Palpitations or pounding heart	[]	[]
Blood		
Hepatitis	[]	[]
Anaemia	[]	[]
High or low Blood Pressure	[]	[]
Varicose Veins	[]	[]
Malaria or Ross River Fever	[]	[]
Other		
Diabetes	[]	[]
Dizzy spells	[]	[]
Epilepsy	[]	[]



Migraines
Ringing in ears

[] []
[] []

Have you ever applied, or are intending to apply, for
Workers Compensation?

Yes [] No []

Details:

Have you had an illness or injury:

Required hospital treatment?
Required treatment by Doctor?
Kept you off work for more than one week?

Yes [] No []
Yes [] No []
Yes [] No []

Details:

Have you ever had an operation?

Yes [] No []

Details:

Smoke?
Drink alcohol?
Take ongoing medication?
Have any present illnesses?
Have any present disability?
Play any regular sport?

Yes [] No []
Yes [] No []
Yes [] No []
Yes [] No []
Yes [] No []
Yes [] No []

_____ per day
_____ per day

Details:

Have you ever had to change a job due to a reaction to chemical, dust, grease or
other?

Yes [] No []

Details:

What type of industries have you worked in before?

Details:

General
Medical
History:



I (your name) declare that the information and answers given on this document are true and correct to the best of my knowledge.

Compensation History Form

WorkCover Qld
PO Box 137
MARYBOROUGH QLD 4650

I

do hereby give NDM Contracting permission to research my compensation history.

Name:

Address:

Date of Birth:

Signed:

Date:



QCLAD PTY LTD

Please save this form and email it to wayne@qlad.com