1. EMPLOYEE DETAILS

SURNAME		**GIVEN NAMES**	
PREFERRED NAME		**GENDER**	
DATE OF BIRTH		**TITLE**	
STREET ADDRESS			
		POST CODE	
POSTAL ADDRESS			
		POST CODE	
EMAIL			
MOBILE NO.		**HOME PHONE NO.**	

EMERGENCY CONTACT – PRIMARY

SURNAME		**GIVEN NAMES**	
STREET ADDRESS			
		POST CODE	
HOME PHONE NO.		**MOBILE NO.**	
RELATIONSHIP			

EMERGENCY CONTACT – SECONDARY

SURNAME		**GIVEN NAMES**	
STREET ADDRESS			
		POST CODE	
HOME PHONE NO.		**MOBILE NO.**	
RELATIONSHIP			

CULTURAL BACKGROUND

I am legally entitled to work in Australia? ☐ YES ☐ NO

I am an Australian Citizen? ☐ YES ☐ NO

Country of Origin: _____

Visa Type: _____ Expiry: _____

I identify myself as Aboriginal, but not Torres Strait Islander? ☐ YES ☐ NO

I identify myself as Torres Strait Islander but not Aboriginal? ☐ YES ☐ NO

I identify myself as Aboriginal and Torres Strait Islander? ☐ YES ☐ NO

2. MEDICAL AND HEALTH DECLARATION

Please indicate whether you have had in the past, or are currently afflicted by the below medical conditions. Additional pages may be added if required.

MEDICAL CONDITION			IF 'YES', DETAILS OF TREATMENT AND LIMITATIONS ON WORK CAPACITY
ASTHMA	☐ YES	☐ NO	
BRONCHITIS	☐ YES	☐ NO	
HEART CONDITIONS	☐ YES	☐ NO	
HIGH/LOW BLOOD PRESSURE	☐ YES	☐ NO	
TYPE 1 OR 2 DIABETES	☐ YES	☐ NO	
HEPATITIS	☐ YES	☐ NO	
FAINTING ATTACKS	☐ YES	☐ NO	
EPILEPSY	☐ YES	☐ NO	
HIATUS HERNIA	☐ YES	☐ NO	
CARPEL TUNNEL SYNDROME	☐ YES	☐ NO	
BACK PROBLEMS	☐ YES	☐ NO	
TENOSYNOVITIS	☐ YES	☐ NO	
TUBERCULOSIS	☐ YES	☐ NO	
ALLERGY	☐ YES	☐ NO	

Have you ever required any prolonged time off work due to an injury or illness? ☐ YES ☐ NO

If 'YES', please provide details:

Is there any other medical condition or specific duties that ARC should be aware of that would prevent you from carrying out your positional duties? ☐ YES ☐ NO

If 'YES', please provide details:

Do you consider yourself to have a disability, impairment or long term condition? ☐ YES ☐ NO

If 'YES', please indicate below:

☐ Hearing Impaired ☐ Medical Condition _____ ☐ Physical

☐ Acquired Brain Impairment ☐ Vision ☐ Learning

☐ Mental Illness ☐ Epilepsy ☐ Intellectual

☐ Other: _____

3. CAPABILITY STATEMENT

The following information will assist ARC Disability to make an informed judgement about the employee's suitability for certain roles and assist in the rostering of support shifts for the employee.

Separate to the employee's capacity to complete certain duties this does not negate their responsibility to undertake a risk assessment of any activities they undertake. If an injury does occur during the course of employment, then the applicable procedure for Serious Injury Management will take effect. Capacity is based on your ability to undertake the tasks during a shift.

CAPACITY OF TASK	1- 2hrs	3-4hrs	5-6hrs	7-8hrs	9hrs +
Duration of shift	☐	☐	☐	☐	☐
CAPACITY OF TASK	**Not at all**	**Up to 25%**	**Up to 50%**	**Up to 75%**	**No Restrictions**
Standing/Walking	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐

CAPACITY OF TASK	Not at all	Occasionally	Frequently	Unrestricted
Bending	☐	☐	☐	☐
Squatting	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Twisting	☐	☐	☐	☐
Reaching Above the Shoulders	☐	☐	☐	☐
Assisting with Hoisting (as an individual)	☐	☐	☐	☐
Assisting with Hoisting (in a team of two)	☐	☐	☐	☐
Assist with Personal Care during support	☐	☐	☐	☐
Assist with Medication during support	☐	☐	☐	☐
Undertake Sleepovers	☐	☐	☐	☐
Lifting < 2kgs	☐	☐	☐	☐
Lifting 2-4kgs	☐	☐	☐	☐
Lifting 4-6kgs	☐	☐	☐	☐
Lifting 6-8kgs	☐	☐	☐	☐

TASK AND DUTY			IF 'YES', DETAILS OF LIMITATIONS ON WORK CAPACITY
Able to work Overtime	☐ YES	☐ NO	
Able to work Weekends	☐ YES	☐ NO	
Able to wear appropriate WHS clothing e.g. closed in shoes	☐ YES	☐ NO	
Able to work in Isolation, within the community and family homes	☐ YES	☐ NO	
Work within a group setting	☐ YES	☐ NO	
Able to support the emotional requirements of the Participant/s	☐ YES	☐ NO	
Able to complete Incident Reports, File Notes, Timesheets and other relevant forms	☐ YES	☐ NO	
Able to drive a Toyota Hi-Ace or similar (up to 12 passengers)	☐ YES	☐ NO	
Able to transport Participants during course of employment within own, or ARC owned vehicles	☐ YES	☐ NO	
Other adjustments to supports, or limitations to consider (not listed above)	☐ YES	☐ NO	

4. PAYROLL DETAILS

SUPERANNUATION

I wish to use ARC's nominated Superannuation Fund? ☐ YES ☐ NO

I wish to use my own nominated APRA or RSA Superannuation Fund ☐ YES ☐ NO

I wish use contribute to my SMSF Superannuation Fund? ☐ YES ☐ NO

FUND NAME			
ACCOUNT NAME			
MEMBERSHIP NO		**FUND ABN**	
UNIQUE SUPER ID			

FUND ESA			*(SMSF Only)*
BSB NO.		**ACCOUNT NO.**	
ACCOUNT NAME			

BANK DETAILS

BANK NAME			
BSB NO.		**ACCOUNT NO.**	
ACCOUNT NAME			

** NOTE: Completing the 'BANK DETAILS' section authorises ARC Disability Services to deposit wages/salary into the above listed bank account.*

SACRIFICING DETAILS

Do you wish to make Voluntary Contributions to your Superannuation Fund? ☐ YES ☐ NO

Do you wish to make a Salary Sacrifice from your Wages*? (*Permanent employees only)* ☐ YES ☐ NO

If 'YES', please complete additional forms provided by HR/Payroll Departments.

5. SKILLS AND QUALIFICATIONS

FORMAL QUALIFICATIONS

Any additional competencies related to the role:

- ☐ Cert III Disability
- ☐ Cert IV Disability (or higher)
- ☐ Cert III Youth Work (or Higher)
- ☐ Cert III Community Services (or Higher)
- ☐ Cert III Child, Youth & Family (Or Higher)
- ☐ Other: _____
- ☐ Other: _____

INTERESTS AND HOBBIES

Please specify any interests/hobbies that may be assist to help identify any additional skills for service areas or client goals:

☐ Art	☐ Manual Arts	☐ Craft / Sewing
☐ Drama	☐ Swimming	☐ Photography
☐ Technology / Computers	☐ Dance	☐ Cooking / Baking
☐ Sport	☐ Gardening	☐ Reading / Writing
☐ Drumming / Percussion	☐ Music	☐ Walking

☐ Others: _____

CLIENT RELATED

Do you have any Client Related Skills and/or experience? ☐ YES ☐ NO

If 'YES', please indicate below:

☐ Autism	☐ Personal Care	☐ Manual Handling
☐ Challenging Behaviours	☐ Suicide Prevention	☐ Non-verbal
☐ Diabetic	☐ Bowel Management	☐ Provent
☐ Hoisting	☐ Colostomy	☐ Vision Impaired
☐ Mental Illness	☐ Epilepsy	☐ Cathertisation
☐ Continence Aids	☐ Hearing Impaired	☐ Medication
☐ P.E.G.	☐ Sensory	☐ Auslan

☐ Other: _____

LANGUAGE

Do you speak a language/s at home other than English? ☐ YES ☐ NO

If 'YES', please list language/s and indicate proficiency:

_____	☐ Limited Working	☐ Professional Working	☐ Native/Bilingual
If Required, are you willing/able to:	☐ Act as Translator?	☐ Act as Interpreter?	
_____	☐ Limited Working	☐ Professional Working	☐ Native/Bilingual
If Required, are you willing/able to:	☐ Act as Translator?	☐ Act as Interpreter?	
_____	☐ Limited Working	☐ Professional Working	☐ Native/Bilingual
If Required, are you willing/able to:	☐ Act as Translator?	☐ Act as Interpreter?	

TRAINING

USI NUMBER:			
CPR NO.		**DATE / ISSUE:**	
FIRST AID NO.		**DATE / ISSUE:**	

6. PROBITY

CRIMINAL HISTORY

Have you been convicted or had any finding of guilt (no conviction recorded) by a court in Queensland, or elsewhere, for the following reasons:

- Having sex with a child (irrespective of the type of relationship e.g. teenage boyfriend/girlfriend, unlawful carnal knowledge); or
- Other child-related sex or pornography offences including possession of child pornography; or
- The murder/attempted murder/manslaughter of a child.

☐ YES ☐ NO

Are you the subject of any of the following:

- Reporting obligations under the Child Protection (Offender Reporting) Act 2004; or
- An offender prohibition order under the Child Protection (Offender Prohibition Order) Act 2008; or
- A disqualification order issued by a court prohibiting them from applying for or holding a Blue Card; or
- A sexual offender order under the Dangerous Prisoners (Sexual Offenders) Act 2003

☐ YES ☐ NO

7. TRANSPORT

LICENCE

DRIVERS LICENCE NO.		**EXPIRY:**	
DRIVERS LICENCE TYPE:		**STATE OF ISSUE:**	

MOTOR VEHICLE

VEHICLE REGISTRATION:		**REGO EXPIRY:**	
VEHICLE MAKE		**VEHICLE MODEL**	
NAME OF OWNER:			

COMPREHENSIVE INSURANCE

INSURER NAME:	
INSURANCE EXPIRY:	

For the purpose of reimbursing approved motor vehicle mileage, please select one of the options below:

☐ As per the Award, I request that Arc Disability Services Inc. pay me travelling allowance as prescribed in the Engagement Summary of my Employment Agreement.

OR

☐ As per the Award, I request that Arc Disability Services Inc. do not pay me travelling allowance as I will claim this during my taxation lodgement.

** NOTE: By listing the above Motor Vehicle and Insurance details you are declaring that this vehicle, which will be provided consent to operate, for work purposes in the provision of service to consumers Disability Services provided by ARC Disability Services Incorporated. You warrant and represent that you are the owner of the vehicle or I have consent of the registered owner of the above listed Motor Vehicle.*

EMPLOYEE ACKNOWLEDGEMENT

By signing this Employee Details, you accept that these details, and any subsequent updates or supporting details, will be kept as a record in your employee personnel file, and you declare all answers written are true, correct. The employee also acknowledges that it is their responsibility to notify ARC of any changes to these details.

SIGNED by the EMPLOYEE:

FULL NAME			
SIGNATURE		**DATE**	

SIGNED by EMPLOYER REPRESENTATIVE:

FULL NAME		**POSITION**	
SIGNATURE		**DATE**	