BETHESDA HEALTH CARE

APPLICATION FOR EMPLOYMENT

Full Name: _____

Position Title: _____

Reference Number: _____ **Location:** _____

Current Bethesda Hospital Staff only:

Current Position: _____ **Current Location:** _____

Date Received _____

Privacy: *Your application form contains personal information, which will be managed in accordance with our Privacy Policy. If you are successful in your application, your form will become an employment record. If you are unsuccessful, your application form will be destroyed/kept for three (3) months before being destroyed.*

APPLICATION FOR EMPLOYMENT

PERSONAL DETAILS:			
First Name(s):		Last Name:	
Preferred Name:			
Title:		Gender:	
Home Address:		Contact Numbers:	Home: Mobile:
Email Address:		Preferred Contact by:	

AHPRA DETAILS (If applicable):			
Date registered:		Registration Number:	
		Expiry Date:	

ADDITIONAL INFORMATION:	
Availability: Days: M☐ T☐ W☐ T☐ F☐ S☐ S☐	
Times: Morning☐ Afternoon☐ Evenings☐ Nights☐	
Have you worked for Bethesda before?	Select
If yes, position held and location:	
Are you a permanent resident/Australian Citizen?	Select
If no, have you been granted a temporary visa/work permit?	Select
If yes, state the period that the visa/work permit is valid.	From: To: Visa Number:
Do you have a national police clearance issued within the past six months?	Select
If not, are you willing to undergo a mandatory national police clearance check?	Select
Do you hold a current Working with Children (WWC) Card?	Select
If yes, please provide the card number and expiration date.	Number: Expire:
If no, are you willing to obtain one? (if applicable)	Select

EDUCATION/QUALIFICATIONS/TRAINING:

Please provide details of any qualifications obtained, training courses attended, or examinations taken if you are still awaiting the results.

Year – From – To	Name of school/college	Qualification attained

Year – From – To	Name of school/college	Qualification attained

Year – From – To	Name of school/college	Qualification attained

PAGE NOT REQUIRED TO BE COMPLETED IF ATTACHING CV.

EMPLOYMENT HISTORY: Please include details of any previous voluntary/unpaid work.	
Employer:	
Position Held / Main Duties:	
Dates: From - To	
Reason for leaving:	

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Position Held / Main Duties:	
Dates: From - To	
Reason for leaving:	

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Dates: From - To	
Reason for leaving:	

APPLICATION DETAILS Explain why you are applying for this position in the space provided below. Please indicate all relevant skills and experience that you hold that you believe would enable you to successfully carry out the duties and responsibilities of this position.

AVAILABILITY: Please provide your interview availability and any upcoming events or holidays planned below.

REFEREES: Please include two referees' with at least one being your current or last employer.	
Name	Position
Company/Relationship	Contact Number
Name	Position
Company/Relationship	Contact Number

PRE-EMPLOYMENT HEALTH QUESTIONNAIRE:			
No	Do you have or have you had any of the following conditions? If yes, please provide further details in the table below.	Answer	
		YES	NO
1	Heart disease, heart attack or angina, high blood pressure		
2	Asthma, wheeze or lung disease		
3	Abdominal ulcers or hernia		
4	Frequent or regular migraine/headaches		
5	Allergies or sinusitis		
6	Eczema, dermatitis or other skin complaints		
7	Anxiety, panic attacks or psychiatric illness, including depression		
8	Visual problems prescription glasses cannot correct		
9	Ear conditions such as deafness or tinnitus		
10	Bloodborne viruses including Hepatitis B, Hepatitis C or human immunodeficiency virus (HIV)		
11	Immunosuppressed including receiving chemotherapy or long-term steroid use		
12	Have you ever been treated for drug or alcohol addiction		
13	Diabetes		
14	Previous back, neck or spinal injury, including whiplash		
15	Sciatica or disc protrusion		
16	Back pain		
17	Spinal operation		
18	Arthritis/rheumatism		
19	Hip/knee/ankle injury		
20	Shoulder/elbow/wrist injury		
21	Chronic joint injury, including stiffness or pain		
22	Shoulder or hip bursitis		
23	RSI/Occupational Overuse syndrome		
24	Bleeding disorder		
25	Muscle/tendon or ligament problem		
26	Carpel tunnel syndrome		
27	Epilepsy, fainting, fits, blackouts or dizzy spells		
28	Any sporting/vehicle illness or injury		

Complete the table below for any questions (1 – 28) answered yes.

Please continue on an additional sheet if you require more space than provided here.

No	Duration and Dates of Condition	Current Status

- Failure to disclose information about a pre-existing medical condition may be deemed misconduct, leading to potential dismissal or other disciplinary actions.
- Do you believe you are fit and physically able to fulfil all the duties required in the role applied for?

  Yes ☐ No ☐

If no, what modifications would be required?

DECLARATION:			
• My answers relating to my medical and employment history are true and complete to the best of my knowledge. Furthermore, there is nothing else regarding my health, wellbeing or ability to carry out the potential role that Bethesda Hospital may need to know to assess me for the position(s) I have applied. • I am fully aware that if I fail to disclose any relevant matter relating to my health, which renders me incapable of properly fulfilling the duties of the position, the employer may not employ me. If already employed by the employer, my employment may be summarily terminated. • I consent to any reference checks necessary to support this application.			
Signature:		Date:	
(If you are applying electronically, you will be required to sign a printout of this application should you proceed in the selection process.)			

Return details:	
Please submit your application to the attention of the recruiting manager by quoting the reference number using one of the options below, or alternatively, you can submit it to hronboarding@bethesda.org.au.	
Submit via email as an attachment to	
Or Mail/deliver to	Bethesda Hospital, 25 Queenslea Drive, Claremont, WA 6010

ALL sections on the pre-employment screening form must be completed.

Failure to provide the required evidence will impact on your eligibility for employment.

IMMUNISATION IS IMPORTANT FOR HEALTHCARE WORKERS (HCWs) *(this includes all staff at Bethesda)* AND VOLUNTEERS.

HCWs are at risk of exposure to vaccine-preventable diseases while at work. Immunisation protects your health and prevents diseases from being spread between you and your family and between you and your patients.

All HCWs must undergo pre-employment screening and vaccination relevant to their role to minimise the risk of disease acquisition and transmission.

Routine screening/immunisation is based on risk assessment according to the role you will be performing.

DISEASE	VACCINATION/SEROLOGY
Measles, Mumps, Rubella	MMR vaccine x 2 doses (1 month apart) or serological (blood test) evidence of immunity.
Varicella (chickenpox)	Varicella x 2 doses (1 month apart) or serological (blood test) evidence of immunity.
Pertussis (whooping cough)	Pertussis vaccine within the last ten (10) years.
Hepatitis B	Age-appropriate vaccination schedule followed by serological (blood test) evidence of immunity
Tuberculosis baseline screening (Clinical staff only)	Mantoux TST/QuantiFERON blood test
Influenza	Annual vaccination recommended (vaccination required for positions in MPaCCS due to the requirement to visit nursing homes)
Coronavirus – SARS COV-2	Vaccination recommended (vaccination required for positions in MPaCCS due to the requirement to visit nursing homes)

IMPORTANT INFORMATION FOR APPLICANTS

Written evidence in English **must** support vaccination history or serology status for vaccine-preventable diseases (VPDs).

Evidence must be provided for tuberculosis (TB) screening (clinical staff) and MRSA (if applicable). You will be notified if either of these tests are required.

Evidence that will be accepted includes:

- Complete official vaccination records (to support the required number of doses of vaccine);
- Serology/blood test results or letter signed by a GP; and
- For TB screening, results of either a baseline Mantoux test or a QuantiFERON blood test.

You may have had screening done recently (at another healthcare facility). You are requested to access these results from your staff health provider and provide a copy to your manager at Bethesda Health Care with your completed form.

Should you:

- ❖ Not be able to provide the evidence listed above, you will be required to undergo further testing before commencing employment with Bethesda Healthcare.
- ❖ Due to allergy or medical reasons, not be able to receive vaccinations or undergo Mantoux testing - a signed letter from your GP/Specialist will be required, or
- ❖ Suffer from ANY infectious disease, this needs to be declared, and you **must** discuss your work practices with Infection Prevention & Control.

PLEASE READ CAREFULLY AND COMPLETE ALL SECTIONS A, B, C, D, E, F and G

Bethesda Health Care is committed to providing an environment that is as safe as possible for all healthcare workers (HCWs), volunteers and patients. Your employment with Bethesda Health Care is subject to your immunity status complying with the Department of Health Western Australia Operational Directive OD0388/12 and National Guidelines. All information provided in this checklist will be treated confidentially, and this information will be stored in a secure place.

All sections must be completed.

PERSONAL DETAILS:					
First Name(s):			Last Name:		
Preferred Name:					
Date of Birth			(For admin purposes only)		
Title:			Gender:		
Home Address:			Contact Numbers:	Home: Mobile:	
Email Address:			Preferred Contact by:		
Position Title:		Department:		**(Admin Only) Risk Class:**	

SECTION A - MRSA *(If YES to either question, MRSA screening is required before you can work clinically – nose and throat swab)* tick *YES or NO*	**Yes ☑**	**No ☑**	**OFFICE USE ONLY ⬇**
Have you worked or been a patient in a hospital outside WA in the past 12 months?	☐	☐	
Have you worked in a residential care facility/nursing home outside of WA in the past 12 months?	☐	☐	

SECTION B - Communicable Diseases *(Vaccine Preventable)*			
	Minimum acceptable evidence of immunity to be provided to IP&C.	**Yes ☑**	**OFFICE USE ONLY ⬇** *(Date/result)*
Measles Mumps Rubella	Documented evidence of two measles, mumps and rubella vaccinations at least one (1) month apart; **OR** Born before 1966 (measles only); **OR** Presence of measles, mumps and rubella antibody (IgG) on serology.	☐ ☐ ☐	
Varicella *(Chicken Pox)*	Documented evidence of two varicella vaccinations at least 1 (one) month apart **OR** Presence of varicella antibody (IgG) on serology	☐ ☐	
Pertussis (Whooping Cough)	One documented dose of adult diphtheria, tetanus and pertussis (dTpa) vaccine in the last ten (10) years	☐	

SECTION C - Hepatitis B Immunisation *(All healthcare workers and volunteers to complete)*	**Yes ☑**	
Documented evidence of an age-appropriate vaccination schedule for hepatitis B?	☐	
Presence of Hepatitis B Antibody on Serology (Blood Test)?	☐	

SECTION D - Recommended Immunisation	Yes ☑	
Influenza and COVID-19 Annual Immunisation	☐	

SECTION E - Assessment of Risk of TB in Clinical HCWs					
What is the Risk of TB infection?			OFFICE USE ONLY *Shaded area*		
			YES ☑		NO ☑
1.	Have you been treated for TB in the past?		☐		☐
2.	Have you had contact, personally or at work, with somebody who suffered from TB?		☐		☐
3.	Country of birth				
4.	What countries have you lived or worked in for more than six months other than your country of birth?				
5.	Are you Aboriginal or a Torres Strait Islander?		☐		☐
	OFFICE USE ONLY	If "Y" to ANY of the above, then Group 2 (yellow) in the algorithm (Appendix B)			

Other information (Copy of results MUST be attached)	YES ☑	NO ☑
Have you had a Mantoux or QuantiFERON skin test before?	☐	☐
Have you had BCG vaccination?	☐	☐
Do you have a medical history of immune deficiency? Or take medicines that reduce immune response?	☐	☐
	☐	☐

SECTION F - Allergies- Drugs/Other
Allergies/drugs/other:
Skin conditions:

SECTION G- Fit testing results	YES ☑	NO ☑
Have you been fit tested for a Particulate Filter Respirator (P2/N95)	☐	☐
If Yes: please provide the brand/size and date of fit test.		

Please confirm you authorise Bethesda to access your immunisation details via the Australian Immunisation Register to assist in managing your ongoing vaccination status YES ☐

If you have any questions or are having difficulty obtaining the evidence required to enable you to commence employment, please contact the Manager, Infection Prevention & Control, on 9340 6300 or via email – IPCStaffHealth@bethesda.org.au/

Employee Signature: _____ **Date:** _____