

# CS NURSING AGENCY PTY LTD - APPLICATION FORM

## 1. PERSONAL DETAILS

Title	First Name	Middle	Surname
Mobile Phone No:		Home Phone:	Fax No:
Email Address			Other Phone No.
Home Address			Postal Address
Next of Kin Name, Address & Phone No.			
Date of Birth		Place of Birth	

## 2. PROFESSIONAL DETAILS

Drivers Licence No.		I have a car <input type="checkbox"/>	Nursing Year of Service (1-8)	
I would like to work in				
<input type="checkbox"/> Surgical	<input type="checkbox"/> Recovery	<input type="checkbox"/> Cath Lab		
<input type="checkbox"/> Medical	<input type="checkbox"/> DPU	<input type="checkbox"/> Maternity		
<input type="checkbox"/> Rehab	<input type="checkbox"/> OT Anaesthetics	<input type="checkbox"/> Nursery		
<input type="checkbox"/> ICU	<input type="checkbox"/> OT Scrub	<input type="checkbox"/> Orthopaedics		
<input type="checkbox"/> CCU	<input type="checkbox"/> OT Scout	<input type="checkbox"/> Other _____		
Post Graduate Experience/Degrees or Certificates: _____				
Approximately how many hours per .....would you like to work?		Week _____	<i>Please circle</i>	
		Fortnight _____	VNO	RN
		Month _____	EN	AIN
Are there any set shifts you would like to work: _____				
Any other current job?	Where?	Nursing Registration or Cert No. NMW		
I can work: AM <input type="checkbox"/>	PM <input type="checkbox"/>	ND <input type="checkbox"/>	Double Shifts <input type="checkbox"/>	Weekends <input type="checkbox"/>
Nursing Registration Expiry Date:-				
Do you have an active workers compensation claim lodged?:		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
With which insurance company? _____				
Do you have a disability arising from a previous or active worker's compensation claim?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Have you ever made a claim against a hospital?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Do you or have you had any injury or illness which will effect your ability to perform your nursing duties:		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
<i>If yes, please provide written details on a separate sheet detailing any ongoing problems.</i>				
I am happy to be called when I am not on call:		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Early morning calls are OK:-
		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Reference 1 – Name & Contact Number:				
Reference 2 – Name & Contact Number:				

## 3. FINANCIAL DETAILS

Tax File Number		Tax me at the highest level:- Yes <input type="checkbox"/> No <input type="checkbox"/>		No. of dependents:
Bank			I am claiming the tax free threshold:- Yes <input type="checkbox"/> No <input type="checkbox"/>	
Branch	BSB (=6 digits)	Account Number (=9 digits)		
Superannuation Company:		Superannuation Policy Number:		

## 4. JOINING CS NURSING AGENCY

I agree to have a Working with Children Check	Yes <input type="checkbox"/> No <input type="checkbox"/>	Signature & Date
I agree to have a Criminal Record Check	Yes <input type="checkbox"/> No <input type="checkbox"/>	
I hereby give my permission for my CV, references, and personal details to be checked	Yes <input type="checkbox"/> No <input type="checkbox"/>	
I will abide by the policies of CS Nursing Agency and the Hospitals at which I will be working.	Yes <input type="checkbox"/>	Interview Date: