Apprentice / Trainee Registration Form

Directions
Workforce Development
Apprenticeships
Training
Careers

General Details

Name _____ Preferred name (if other) _____

Date of Birth ____ / ____ / _____ Gender: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say

Residential address _____ P/C _____

Postal address (if different) _____ P/C _____

Contact number: _____ Email: _____

Next of kin name: _____ Phone:_____ Email: _____

CITIZENSHIP ☐ Australian Citizen ☐ Permanent Resident ☐ Other – Please specify _____

Are you of Aboriginal or Torres Straight Islander decent?	☐ YES	☐ NO
Are you willing to work away from home?	☐ YES	☐ NO
Have you been convicted of a criminal offence in the last 5 years?	☐ YES	☐ NO
Are you willing to obtain a Police Clearance or Working with Children certificate if required?	☐ YES	☐ NO
Are you willing to undertake drug and alcohol screening?	☐ YES	☐ NO
Have you been unemployed for more than 6 months?	☐ YES	☐ NO

JSID_____

If you applied for a position through the Directions website, skip this section and go to the next.

I am interested in an _____ ☐ apprenticeship ☐ traineeship

Are you interested in any other trades or occupations? _____

I prefer to work ☐ in the Perth metro ☐ Anywhere in WA ☐ I am willing to work FIFO

I prefer to work ☐ Full time ☐ Part time (usually 20 hours per week)

Are you still attending high school? ☐ YES ☐ NO

Highest year of schooling completed : ☐ Year 9 ☐ Year 10 ☐ Year 11 ☐ Year 12 In what year was that? _____

✓ **You have attached a copy of your current resume.**

Have you completed any qualifications that are not listed on your resume? If yes, please list including year completed:

_____

_____

Do you hold a current valid WA drivers licence? ☐ YES Classes held: _____ ☐ NO

Do you currently hold any other licences? ☐ YES Type held: _____ ☐ NO

Have you previously been employed as an apprentice/trainee? ☐ YES ☐ NO

Employer: _____

Reason for it ceasing: _____

How did you hear about Directions?

☐ A current Directions employee	☐ A former Directions employee	☐ Sent by Host Company
☐ School	☐ Job vacancy ad on _____	☐ Directions website
☐ Google	☐ A careers event/expo	☐ Friend or parent
☐ Facebook	☐ LinkedIn	☐ Other – specify _____

Pre-employment Health Assessment

To help us comply with our obligations and commitment to a safe workplace we need to ask some health related questions to enable us to determine whether applicants can safely and adequately perform the duties required of the position.

Please complete the following **Pre-employment Health Assessment** providing all relevant details of any conditions or injuries identified. You are required to answer these questions as truthfully and accurately as possible as it may affect your right to make a compensation claim for any injury or harm that may occur during your employment with Directions.

This information will be treated as confidential and in accordance with our Privacy Statement and applicable law.

You may also be required to attend medical assessment which may include a screening for drugs and alcohol.

General Health and Fitness

Do you currently take any medications that may impact your ability to work or train? Please list if yes:

Name of medicine	Reason *(e.g. high blood pressure)*	Date started	Taken regularly? Y / N

Are you currently receiving medical treatment for any illness, injury or medical condition? ☐ YES ☐ NO

Have you ever had any serious injuries, illness, mental or physical, which required medical treatment for a period of one week or more? ☐ YES ☐ NO

If you answered YES to any of these questions, please provide details such as type/location/how long ago etc.

_____

Do you have OR have you ever suffered from any of the following?

Concussion or head injury	☐ YES	☐ NO	Migraine/persistent headaches	☐ YES	☐ NO
Epilepsy	☐ YES	☐ NO	Fainting or blackout episodes	☐ YES	☐ NO
Cancer/tumours	☐ YES	☐ NO	Dermatitis/Eczema or similar	☐ YES	☐ NO
Liver problems/hepatitis	☐ YES	☐ NO	Tropical diseases e.g. Ross River Virus	☐ YES	☐ NO
Allergies	☐ YES	☐ NO			

If you answered YES to any of these questions, please provide details such as type/location/how long ago etc.

_____

Please tick any activity listed that you would currently have difficulty undertaking:

Walking on uneven or slippery ground	☐	Running 100 metres	☐
Crouching or bending repeatedly	☐	Kneeling	☐
Climbing a ladder	☐	Standing for over 2 hours	☐
Sitting for over 2 hours	☐	Lifting 25 kilograms	☐
Balancing	☐	Repetitive movements of hands or arms	☐
Gripping firmly with both hands	☐	Reading small print	☐
Turning your head rapidly	☐	Wearing personal protective equipment (PPE)	☐
Using hand tools	☐	Working in confined spaces	☐
Hearing a normal conversation	☐	Working in extreme temperatures	☐
Concentrating on a task	☐	Working at heights	☐

Have you been treated for any illness, injury or side effect resulting from exposure to a chemical or toxic substance or radiation? ☐ YES ☐ NO

Do you suffer from any medical condition or health related condition that may be affected by exposure to chemicals? ☐ YES ☐ NO

If you answered YES to any of these questions, please provide details such as type/location/how long ago etc.

_____

Occupational Health

Do you have or have you ever had a work related illness or injury? ☐ YES ☐ NO

Have you ever had a workers compensation claim? ☐ YES ☐ NO

If yes: Type of injury/illness _____

Date claim lodged _____ / _____ / _____

Date claim closed _____ / _____ / _____

What treatment was required? (*e.g. surgery, physiotherapy*) _____

Did vou return to normal duties? ☐ YES ☐ NO

Musculoskeletal Health

Do you have or have you ever had an injury or experienced pain/discomfort in any of the following?

Neck	☐ YES	☐ NO	Lower back	☐ YES	☐ NO
Shoulder	☐ YES	☐ NO	Hip	☐ YES	☐ NO
Elbow	☐ YES	☐ NO	Knee	☐ YES	☐ NO
Wrist or hand	☐ YES	☐ NO	Ankle or foot	☐ YES	☐ NO

Do you have or have you ever experienced any of the following symptoms?

Sciatica (weakness/tingling in legs)	☐ YES	☐ NO	Unexplained pins and needles	☐ YES	☐ NO
Unexplained muscle aches and pains	☐ YES	☐ NO	Unexplained joint aches and pains	☐ YES	☐ NO

Do you have or have you ever experienced any of the following conditions?

Repetitive strain injury	☐ YES	☐ NO	Rheumatoid arthritis	☐ YES	☐ NO
Tennis elbow	☐ YES	☐ NO	Osteoporosis	☐ YES	☐ NO
Carpal tunnel syndrome	☐ YES	☐ NO	Fibromyalgia	☐ YES	☐ NO
Hernia	☐ YES	☐ NO	Broken/fractured bones	☐ YES	☐ NO
Osteoarthritis	☐ YES	☐ NO	Any other condition that affects muscles, joints or bones?	☐ YES	☐ NO

Cardiovascular Health

Have any of your direct family members ever had heart problems such as high blood pressure, heart attack, etc.? ☐ YES ☐ NO

Have you undergone chest or heart surgery? ☐ YES ☐ NO

Do you have or have you ever experienced any of the following conditions?

Heart disease	☐ YES	☐ NO	Angina (chest pains)	☐ YES	☐ NO
Heart murmurs	☐ YES	☐ NO	High blood pressure	☐ YES	☐ NO
Palpitations or irregular heart beat	☐ YES	☐ NO			

If you answered YES to any of these questions, please provide details such as type/how long ago etc.

_____

_____

Respiratory Health

Do you have or have you ever experienced any of the following conditions?

Wheezing asthma or exercise induced asthma	☐ YES	☐ NO	Chronic obstructive pulmonary disease	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO	Rheumatic fever	☐ YES	☐ NO
Hay fever	☐ YES	☐ NO	Bronchitis	☐ YES	☐ NO

Have you ever experienced an unexplained shortness of breath? ☐ YES ☐ NO

Learning Ability

Have you been diagnosed with any of the following learning disorders?

ADHD	☐ YES	☐ NO	Dyscalculia	☐ YES	☐ NO
Dyslexia	☐ YES	☐ NO	Dysgraphia	☐ YES	☐ NO
Dyspraxia	☐ YES	☐ NO	Any other learning disorder	☐ YES	☐ NO

Mental Health

Do you have or have you ever had a mental health issue requiring medication or counselling? ☐ YES ☐ NO

Have you ever had a problem with drug or alcohol abuse? ☐ YES ☐ NO

Do you have or have you ever had any of the following conditions?

Depression	☐ YES	☐ NO	Insomnia	☐ YES	☐ NO
Panic attacks	☐ YES	☐ NO	Anxiety	☐ YES	☐ NO
Any other mental health condition	☐ YES	☐ NO			

Ear and Eye Health

Do you have any hearing loss?		☐ YES	☐ NO
Do you have or have you ever had earaches, ear infections or discharge from your ears?		☐ YES	☐ NO
Do you have or ever been required to use a hearing aid?		☐ YES	☐ NO
Do you have or have you ever had an eye injury or condition?		☐ YES	☐ NO
Do you wear glasses or contact lenses for either near or distance vision?		☐ YES	☐ NO
Are you colour blind?	☐ DON'T KNOW	☐ YES	☐ NO
	Have you ever been tested for colour blindness?	☐ YES	☐ NO
Have you ever had surgery in relation to your ears or eyes? e.g. laser eye surgery		☐ YES	☐ NO

If you answered YES to any of these questions, please provide details such as type/location/how long ago etc.

_____

Fatigue & Heat Management

Do you have or have you ever had a sleep disorder e.g. sleep apnoea, narcolepsy?	☐ YES	☐ NO
Do you suffer from spells of complete exhaustion?	☐ YES	☐ NO
Have you ever had a problem with prolonged shift work?	☐ YES	☐ NO
Have you ever worked in a very hot environment?	☐ YES	☐ NO
Have you ever had a heat related illness e.g. heat stroke, heat exhaustion?	☐ YES	☐ NO
Have you ever had any treatment that reduces your capacity to sweat?	☐ YES	☐ NO
Do you have diabetes, thyroid problems or any other hormonal condition?	☐ YES	☐ NO
Do you have or have you ever had kidney stones, bladder stones or renal colic?	☐ YES	☐ NO

Vaccinations

Have you had a tetanus injection in the last 3 years?			☐ YES	☐ NO
Have you been vaccinated for Hepatitis A / B			☐ YES	☐ NO
Are you vaccinated for COVID-19?	☐ Triple vaccinated	☐ Double vaccinated	☐ Partially	☐ NO
	Date of most recent vaccine: ____ / ____ / _____			

- Do you believe there is **any** other condition or disability, not listed above, which may restrict or prevent you from performing all the requirements of the position/training? ☐ YES ☐ NO

  If yes, please provide details: _____

Privacy

The above information may be provided to external businesses or government agencies for the purposes of securing an employment and training opportunity for the applicant. The information will not be shared with any other third party or for any other reason other than as required by law.

Declaration

☐ I understand that my application will remain active for three (3) months after which time it will be destroyed in a secure and confidential manner. If I have not been in contact during that time, I understand I may be required to re-register.

☐ I declare that the statements made in this registration form are true and correct and any attached documents are true and correct copies of the original documents. I understand that if I supply any false, incomplete or misleading information on this form or during any medical assessment that may arise from my registration/application, I will – if accepted for employment – be liable for dismissal without notice.

☐ I authorise the taking of my photograph for record keeping purposes, and images being taken of me in a work or training context. I authorise Direction to use those images in communications regarding Directions' services or operation or for promotional purposes.

☐ By signing this registration form I agree to all of the above. I understand that if I am under eighteen (18) years of age, parental/guardian consent will be required before entering into any training agreement.

Signature of registrant _____ Date ____ / ____ / 20___

Signature of Parent/Guardian _____ Date ____ / ____ / 20___

Completed form should be returned to Directions, 7 Sayer Street MIDLAND WA 6056 Email: enquiries@directionswa.com.au Fax 9274 3914