



EMPLOYMENT APPLICATION FORM GENERAL EMPLOYMENT

For Office Use Only: Interview Date: _____
 Interview Time: _____
 Conducted By: _____
 Location: _____

Position Sought: _____

PERSONAL INFORMATION:

First Name: _____

Surname: _____

Address: _____

Mobile Number: _____

Home Number: _____

Email Address: _____

D.O.B.: _____

Male:

Female:

PPS Number _____

Available to start date? _____

Do you require a VISA to work in Ireland?

Yes

No

Professional ID Number, if applicable: _____

Expiry Date: _____

Position Sought: _____

Are you currently employed?

Yes

No

Required Salary: € _____

per hour/
annual salary

Do you have a full & current driving license?

Yes

No

Have you ever been convicted of a criminal offence?

Yes

No

If yes, please comment: _____

Have you been Garda vetted within the last 2 years?

Yes

No

Are you willing to undergo this process?

Yes

No

HEALTH

Are you in good health?

Yes

No

Are you prepared to go through a full medical if necessary?

Yes

No

Are you a registered disabled person?

Yes

No

Do you have any allergies?

Yes

No

If yes, please provide certification number: _____

If yes, please provide details: _____

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DECLARATION OF HEALTH

Declaration of Health: Have you had or do you suffer from any of the following. Please tick the appropriate box. If the answer is Yes please provide further details in comment area.

	<i>(Please tick)</i>				Comment
Epilepsy	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Rheumatic Fever	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Disabling Headache	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Fainting Attacks	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Diabetes	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Kidney Infections	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Asthma	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Postural Deformity	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Flat feet, Back trouble	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Drug Addiction	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Mental Illness	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Hearing Defects	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Sight Defects	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Have you been immunised or vaccinated in the last 5 years?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
What other previous illness or injury have you had? (if any operation, please give details)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Date of last Chest X-Ray:					
Name and Address of Family Doctor:					

I declare that to the best of my knowledge and belief the answers I have provided in this Declaration of Health are accurate.

Signature:		Date:	
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EDUCATION			
School	Name and Location	Award (Detail)	Major/ Subjects of Study
Leaving Cert:			
Junior Cert:			
Degree:			
Diploma:			
Certificate:			
Other:			
Specialised Training:			
Diploma:			
Trade School:			
Continuous Professional Development:			
Professional Affiliations:			
<i>Please list your areas of highest proficiency, special skills or other items that may contribute to your abilities in performing the above mentioned position.</i>			

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WORK EXPERIENCE			
Most Recent Position			
Company Name:			
From (Date):		To (Date):	
Location:			
Role and Title:			
Reason for Leaving:			
Main Responsibilities:			

EARLIER WORK EXPERIENCE			
Company Name:			
From (Date):			
To (Date):			
Location:			
Role and Title:			
Reason for Leaving:			
Main Responsibilities:			

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REFERENCES

Please provide the name, postal address, telephone numbers, employment position and e-mail addresses of three appropriate work referees, one of which must be your current or your most recent employer and indicate whether we are authorised to contact the referee, or not. (Relatives are not acceptable as referees)

	1	2	3
Referee Name:			
Referee Address:			
Employment Position of Referee:			
Contact Telephone Number:			
Email address: (please write carefully)			
May we contact the referee?			

FOR OFFICE USE ONLY

	Please select	Email		Post		Email		Post		Email		Post	
Date Reference & Questionnaire sent:													
Date Reference Received:													
Date Reference Verified Verbally:													

I confirm that the information contained within this application form, and the DETAILS PROVIDED in support of my application on my CURRICULUM VITAE, are both accurate and I understand that any false information or deliberate omissions may disqualify me from employment or render me liable to dismissal.

Signature:		Date:	
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