# John Miller Limited

# APPLICATION FOR EMPLOYMENT - DRIVER

## Personal Details

First Names \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Postcode \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need a permit to work in the UK? Yes/No

Do you hold a UK passport? Yes/No

Have you any convictions (other than spent convictions under the Rehabilitation of Offenders Act 1974)? Yes/No

If Yes, please give full details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Your Application

Have you worked for John Miller Transport before? Yes/No

Are you related to anyone employed by John Miller Transport? Yes/No

How much notice are you required to give your current employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Licences/Certificates held

Do you have a current driving licence Yes/No

If yes, please supply date passed\_\_\_\_\_\_\_\_\_\_

If yes, do you have any endorsements? (give details)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any further licences? LGV 1/LGV 2/Both/Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date passed\_\_\_\_\_\_\_\_\_\_\_

Please give details of any endorsements\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Accidents/Bans

Please provide details of any accidents you have been involved in during the past 3 years

 ( including accidents with your own motor vehicle(s) )

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Description of accident** | **Date** | **Fines imposed** | **Points received on licence** |  |
|  |  |
|  |  |  |  |  |  |
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Please provide details of any driving bans imposed against you in the past 10 years

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Description of Ban** | **Date** | **Fines imposed** | **Driving bans period** |  |
|  |  |
|  |  |  |  |  |  |
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## Work Experience

Starting with your most recent, please summarise your last 5 years’ work experience. If at any time during this period you were not in employment please detail the reasons and dates below.

|  |  |  |  |
| --- | --- | --- | --- |
| Employer’s Name and Address | Date | Description of job/duties | Reason for leaving  |
| From | To |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Please set out below any further information to support your application, eg past achievements, future aspirations, personal strengths.(please use extra paper if required)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## Health

Do you consider yourself to have a physical or mental disability or long-term medical condition that affects you in your normal day to day activities. Yes/No

Please complete the attached Medical questionnaire.

How many days were you absent through illness or injury in the last 12 months?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## References

All employment offers are subject to satisfactory references being obtained. We require contact details of two people, your most recent employer and one other from the last five years if applicable. References will only be sought once an offer of employment has been made.

|  |  |
| --- | --- |
| Name: | Name: |
| Position: | Position |
| Company Name: | Company Name: |
| Address: | Address |
|  |  |
| Post Code | Post Code |
| Tel No: | Tel No: |

## Declaration

I confirm that the information given on this form is, to the best of my knowledge, true and complete. Any false statement may be sufficient cause for rejection, or if employed dismissal.

I understand these details will be held in confidence by Company, for the purposes of assessing this application, ongoing personnel administration and payroll administration (where applicable) in compliance with the Data Protection Act 1998.

### Signature Date

### FOR INTERNAL USE

Date application received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date application acknowledged\_\_\_\_\_\_\_\_\_\_

Shortlisted for interview Yes/No

If no, reasons \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Names of Interviewers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date/Time of interview\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not appointed after interview reasons\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date regret letter sent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date offer letter sent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Offer accepted Yes/No Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

References received 1 2

EMPLOYMENT MEDICAL QUESTIONNAIRE

**POSITION APPLIED FOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The following information will be treated in the strictest confidence.**

**PERSONAL (Please complete this section in BLOCK CAPITALS)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Full Name:** |  | **Name of Doctor:** |  |  |
| **Address:** |  | **Address of Doctor:** |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Private Tel. No.:** |  |  |  |  |
|  |  |  |  |  |

**Please answer the following questions. If the answer is YES then please provide full details.**

**Have you at any time suffered from the following conditions:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ALLERGIES** |  | **GENITO-URINARY** |  | **NEUROLOGICAL** |
|  |  |  |  |  |  |  |  |
| **Allergies** | **YES/NO** |  | **Kidney stones** | **YES/NO** |  | **Dizzy spells** | **YES/NO** |
| **Asthma** | **YES/NO** |  | **Pain on urination** | **YES/NO** |  | **Epilepsy** | **YES/NO** |
| **Hay Fever** | **YES/NO** |  | **Sugar/albumin urine** | **YES/NO** |  | **Fainting attacks** | **YES/NO** |
|  |  |  |  |  |  | **Paralysis** | **YES/NO** |
| **CARDIOVASCULAR** |  | **MISCELLANEOUS** |  | **Severe headaches** | **YES/NO** |
|  |  |  |  |  |  |  |  |
| **Chest pain** | **YES/NO** |  | **Anaemia** | **YES/NO** |  | **RESPIRATORY** |
| **Heart disorder** | **YES/NO** |  | **Anxiety** | **YES/NO** |  |  |  |
| **High blood pressure** | **YES/NO** |  | **Blood disorder** | **YES/NO** |  | **Chronic cough** | **YES/NO** |
| **Palpitations** | **YES/NO** |  | **Cancer** | **YES/NO** |  | **Pleurisy** | **YES/NO** |
| **Rheumatic fever** | **YES/NO** |  | **Depression** | **YES/NO** |  | **Pneumonia** | **YES/NO** |
|  |  |  | **Diabetes** | **YES/NO** |  | **Sinusitis** | **YES/NO** |
| **DIGESTIVE SYSTEM** |  | **General Debility** | **YES/NO** |  | **Tuberculosis** | **YES/NO** |
|  |  |  | **Insomnia** | **YES/NO** |  |  |  |
| **Hernia** | **YES/NO** |  | **Skin disorder** | **YES/NO** |  | **SENSES** |
| **Jaundice** | **YES/NO** |  |  |  |  |  |  |
| **Peptic Ulcer** | **YES/NO** |  | **MUSCULOSKELETAL** |  | **Colour blindness** | **YES/NO** |
| **Rectal bleeding** | **YES/NO** |  |  |  |  | **Ear disorder** | **YES/NO** |
|  |  |  | **Arthritis** | **YES/NO** |  | **Eye disorder** | **YES/NO** |
|  |  |  | **Backache** | **YES/NO** |  | **Nose disorder** | **YES/NO** |
|  |  |  | **Back Injury** | **YES/NO** |  | **Throat disorder** | **YES/NO** |
|  |  |  | **Disc disorder** | **YES/NO** |  |  |  |
|  |  |  | **Gout** | **YES/NO** |  |  |  |
|  |  |  | **Joint/Tendon disorder** | **YES/NO** |  |  |  |
|  |  |  | **Rheumatism** | **YES/NO** |  |  |  |

EMPLOYMENT MEDICAL QUESTIONNAIRE

Full Details if applicable

**Medical Health & Fitness Declaration**

Driver Name: Driver Signature:

Date: