John Miller Limited

APPLICATION FOR EMPLOYMENT - DRIVER

Personal Details

First Names _____ Surname_____

Address _____

_____

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	

Please provide details of any driving bans imposed against you in the past 10 years

Description of Ban	Date		Fines imposed	Driving bans period	

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)

_____

_____

_____

_____

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**

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

Allergies	**YES/NO**
Asthma	**YES/NO**
Hay Fever	**YES/NO**

CARDIOVASCULAR

Chest pain	**YES/NO**
Heart disorder	**YES/NO**
High blood pressure	**YES/NO**
Palpitations	**YES/NO**
Rheumatic fever	**YES/NO**

DIGESTIVE SYSTEM

Hernia	**YES/NO**
Jaundice	**YES/NO**
Peptic Ulcer	**YES/NO**
Rectal bleeding	**YES/NO**

GENITO-URINARY

Kidney stones	**YES/NO**
Pain on urination	**YES/NO**
Sugar/albumin urine	**YES/NO**

MISCELLANEOUS

Anaemia	**YES/NO**
Anxiety	**YES/NO**
Blood disorder	**YES/NO**
Cancer	**YES/NO**
Depression	**YES/NO**
Diabetes	**YES/NO**
General Debility	**YES/NO**
Insomnia	**YES/NO**
Skin disorder	**YES/NO**

MUSCULOSKELETAL

Arthritis	**YES/NO**
Backache	**YES/NO**
Back Injury	**YES/NO**
Disc disorder	**YES/NO**
Gout	**YES/NO**
Joint/Tendon disorder	**YES/NO**
Rheumatism	**YES/NO**

NEUROLOGICAL

Dizzy spells	**YES/NO**
Epilepsy	**YES/NO**
Fainting attacks	**YES/NO**
Paralysis	**YES/NO**
Severe headaches	**YES/NO**

RESPIRATORY

Chronic cough	**YES/NO**
Pleurisy	**YES/NO**
Pneumonia	**YES/NO**
Sinusitis	**YES/NO**
Tuberculosis	**YES/NO**

SENSES

Colour blindness	**YES/NO**
Ear disorder	**YES/NO**
Eye disorder	**YES/NO**
Nose disorder	**YES/NO**
Throat disorder	**YES/NO**

EMPLOYMENT MEDICAL QUESTIONNAIRE

Full Details if applicable

Medical Health & Fitness Declaration

Driver Name: Driver Signature:

Date: