

|                 |                                  |                                   |                     |
|-----------------|----------------------------------|-----------------------------------|---------------------|
| <b>CONNELLY</b> | <b>Employee Application Form</b> | <b>QF 25</b>                      | <b>Issue No. 01</b> |
|                 |                                  | <b>Issue date:<br/>01/02/2015</b> | <b>Page 1 of 8</b>  |

FOR OFFICE USE ONLY: **CONNELLY**  
Date Appl. Received: \_\_\_\_\_ Reviewed by: \_\_\_\_\_  
Job category to be filed under: \_\_\_\_\_ Filed by: \_\_\_\_\_

**APPLICATION FORM / UPDATING OF EMPLOYMENT RECORDS**

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

APPLICATION FORM FOR DIRECT EMPLOYEE

Phone Interview  
Personal Interview

Please complete in Block Capitals

Application Form Posted to Office  
Internet

|                          |
|--------------------------|
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |

Insert  
Passport size  
Photo  
Here

Surname: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Forename: \_\_\_\_\_

Address \_\_\_\_\_

PPS No. \_\_\_\_\_

E mail Address \_\_\_\_\_

Land Line Tel. No. \_\_\_\_\_ Mobile No. \_\_\_\_\_

**In the event of an accident or emergency who is to be contacted**

\_\_\_\_\_

\_\_\_\_\_

*(Please provide two names and numbers)*

To Apply for a certificate of Tax Credits please tick the box to request a Form 12A

Have you worked previously within this tax year ? Yes  No

If yes, have you received your P45 from your previous employer? Yes  No

*(If yes, please provide this to your new employer)*

**PREVIOUS EXPERIENCE**

| <b>Dates: From→To</b> | <b>Employers Name and Address</b> | <b>Telephone No. and Name for Reference</b> | <b>Position Held</b> |
|-----------------------|-----------------------------------|---|----------------------|
|                       |                                   |   |                      |
|                       |                                   |   |                      |
|                       |                                   |   |                      |

Name of current or most recent employer: \_\_\_\_\_

If currently employed, can contact be made with current employer? ..... Yes  No

Are you permitted to work in Ireland Yes  No

Do you hold a work permit Yes  No

*(If applicable, please attach copy of work permit)*

**In the event of I being employed by the company, I undertake to carry out the necessary training and attend courses and pay the cost of same at my own expense. I agree to work for a probationary period of up to 9 months for the company.**

Signed \_\_\_\_\_

**QUALIFICATIONS / EDUCATION**

| <b>University/College/School</b> | <b>Date Taken</b> | <b>Subject</b> | <b>Grade</b> |
|----------------------------------|-------------------|----------------|--------------|
|                                  |                   |                |              |
|                                  |                   |                |              |
|                                  |                   |                |              |
|                                  |                   |                |              |

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**Other Information** (any relevant experience or training courses you have attended etc..)

|  |
|--|
|  |
|  |
|  |
|  |
|  |

Are you prepared to work : Days  / Evenings  / Saturdays  / Sundays  / Bank Holidays

**Additional Information:**

Please use this space to give any information which you think is relevant but is not covered elsewhere.

|  |
|--|
|  |
|--|

Please explain how you believe that your current skills, experience and qualifications enable you to meet the essential requirements for

|  |
|--|
|  |
|--|

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**Complete as appropriate the following sections: (IF RELEVANT)**

**Please tick each box depending on level of skill and/ or experience in each operation**

| <b>GENERAL</b>          | <b>I HAVE</b>                   | <b>I AM</b>            | <b>SPECIFIC</b>             | <b>DO YOU HAVE?</b> | <b>HOW MANY YEARS EXPERINCE?</b> |
|-------------------------|---------------------------------|------------------------|-----------------------------|---------------------|----------------------------------|
| <b>Operation</b>        | <b>Basic skill or knowledge</b> | <b>Fully Competent</b> | <b>Operation</b>            | <b>Current CSCS</b> |                                  |
| Labouring               |                                 |                        | 180o excavator              |                     |                                  |
|                         |                                 |                        | 360o excavator              |                     |                                  |
| Steelfixing             |                                 |                        | Mini Digger                 |                     |                                  |
| Formwork                |                                 |                        | Dumper                      |                     |                                  |
| Concreting              |                                 |                        | Teleporter                  |                     |                                  |
| Carpentry               |                                 |                        | MEWP                        |                     |                                  |
| Blockwork               |                                 |                        | Lorry Driving               |                     |                                  |
| Plastering              |                                 |                        | Loading Shovel              |                     |                                  |
| Plumbing                |                                 |                        | Scaffolding                 |                     |                                  |
| Pipelaying              |                                 |                        | Banksman/Slinger            |                     |                                  |
| Kerb laying             |                                 |                        | Signing, Lighting, guarding |                     |                                  |
| Mechanic / Fitter       |                                 |                        |                             |                     |                                  |
| Other Skills            |                                 |                        |                             |                     |                                  |
| Abrasive Wheels         |                                 |                        |                             |                     |                                  |
| Confined Space Training |                                 |                        |                             |                     |                                  |
| Shoring / trenching     |                                 |                        |                             |                     |                                  |

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|  |     |    |
|--|-----|----|
|  | Yes | NO |
| Do you have a mobile number? and if yes state number<br>Mobile No. _____<br><i>(write figures clearly)</i> |     |    |
| Are you prepared to answer it and return calls related to work?  |     |    |

Are you prepared to work : Days  / Evenings  / Saturdays  / Sundays  / Bank Holidays

- Do you have a current Fas Safe Pass Card ..... Yes  No
- Do you have a current Fas CSCS ticket and /or CITB approved CSCS Ticket ..... Yes  No
- If yes, for what categories ? \_\_\_\_\_
- Do you have a current Irish Rail PTS Card ..... Yes  No
- Do you have a current Occupational First Aid Certificate ..... Yes  No
- Do you have a current Manual Handling Certificate ..... Yes  No
- Any other relevant certificates ..... Yes  No

***Please attach a copy of Safe Pass Card, PTS Card, Driving Licence and all other Certificates and Tickets where applicable***

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**HEALTH DECLARATION**

|                |  |
|----------------|--|
| <b>NAME</b>    |  |
| <b>ADDRESS</b> |  |

**Medical Questionnaire /Please indicate if any of the following apply or have ever applied to you in the past.**

|  | <b>Yes, please specify</b> | <b>No</b> |
|--|----------------------------|-----------|
| Circulatory problems such as varicose veins, phlebitis, thrombosis                                     |                            |           |
| Heart problems such as angina, high blood pressure, heart attack                                       |                            |           |
| History of heart problems in the family?   |                            |           |
| Chest problems such as asthma or chest pains   |                            |           |
| Diabetes   |                            |           |
| Epilepsy or fainting attacks or dizziness  |                            |           |
| Skin problems/disorders or allergies (e.g dermatitis etc..)  |                            |           |
| Operation or fracture in the past 5 years?   |                            |           |
| Have you had, Back trouble, strain, lombago,arthritis, rheumatism                                      |                            |           |
| Injury to bones, joints, tendons, including wrist tendons that can be aggravated by physical activity? |                            |           |
| Have you ever suffered from or been treated for mental illness?  |                            |           |
| Have you any problems with eyes/sight, other than corrected by glasses?                                |                            |           |
| Have you any hearing problems?   |                            |           |
| Have you ever had high or low Blood Pressure   |                            |           |
| Have you ever had T.B.   |                            |           |
| Do you have a problem with or fear of heights?   |                            |           |
| Any medical Allergies ?  |                            |           |
| Do you smoke (if yes how many per day)?  |                            |           |
| Do you know what weils disease is?   |                            |           |

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|   | Yes, please specify | No |
|---|---------------------|----|
| Have you ever suffered a work related injury ?<br>Year of injury _____<br>If yes, please specify nature of injury, period of absence and outcome.   |                     |    |
| Are you currently taking any prescribed drugs, medicines, tablets or any other treatment ? (If yes, give details privately, through a Private Medical attendance form, your doctor or refer to previous declarations for any continuous treatment.) |                     |    |
| Are you having regular medical reviews, inspections or Consultations or awaiting results of any medical investigations in connection with the following :   |                     |    |
| a) Personal Injury<br>b) Alcohol, Drug or Substance Abuse<br>c) Depression, Anxiety, Stress, Nervous Breakdown, Insomnia or Fatigue ?   |                     |    |
| Have you ever taken non—prescription drugs?   |                     |    |
| Have you ever taken drugs except for medical purposes ?<br>If yes, on what date _____ / _____ / _____   |                     |    |
| Are you willing to submit to a drug test now or in the future at random?  |                     |    |

**What is the longest period for which you have drawn sick pay, disability or welfare benefit from a previous employer's scheme, Insurers or Social Welfare? \_\_\_\_\_ weeks. \_\_\_\_\_ Days. If longer than 10 days in any year give details of illness/absence**

\_\_\_\_\_

**Have you ever made a claim for personal injury or unfair dismissal against any employer? Yes \_\_\_\_ No \_\_\_\_.**

**If yes, give brief details of claim outcome/order by court, tribunal, Insurance company.**

\_\_\_\_\_

**Have you ever had a serious injury outside work? (e.g. car accident or other) Yes \_\_\_\_ No \_\_\_\_.**  
**If yes, give brief details of claim outcome/order by court, Insurance Company**

\_\_\_\_\_

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**Please provide the name and address of your family Doctor / Specialist**

Name: \_\_\_\_\_

Address:  
\_\_\_\_\_

**I declare that the above statements are true and accurate. I understand that a consequence of providing inaccurate information or supplying untruthful replies may result in the termination of my employment.**

Signed \_\_\_\_\_ Employee Date \_\_\_\_\_

Signed \_\_\_\_\_ HR Manager/Dept Date \_\_\_\_\_