

EMPLOYMENT

PLEASE START WITH YOUR MOST RECENT EMPLOYMENT, INCLUDING TRAINING, MILITARY SERVICE AND TIMES OF UNEMPLOYMENT. BRIEFLY DESCRIBE THE MAIN DUTIES AND RESPONSIBILITIES.

NAME AND ADDRESS OF EMPLOYER	JOB TITLE	SALARY	REASON FOR LEAVING
	MAIN RESPONSIBILITIES:		
DATE FROM:			
DATE TO:			
TELEPHONE NO.			

NAME AND ADDRESS OF EMPLOYER	JOB TITLE	SALARY	REASON FOR LEAVING
	MAIN RESPONSIBILITIES:		
DATE FROM:			
DATE TO:			
TELEPHONE NO.			

NAME AND ADDRESS OF EMPLOYER	JOB TITLE	SALARY	REASON FOR LEAVING
	MAIN RESPONSIBILITIES:		
DATE FROM:			
DATE TO:			
TELEPHONE NO.			

HAVE YOU EVER BEEN DISMISSED FROM A POST BECAUSE OF MISCONDUCT OR RESIGNED PENDING THE RESOLUTION OF DISCIPLINARY PROCEEDINGS AGAINST YOU? YES NO IF YES PLEASE GIVE DETAILS ON A SEPARATE SHEET.

OTHER INFORMATION

IF THERE IS ANY OTHER QUALIFICATION, SKILLS, EXPERIENCE AND APTITUDES RELEVANT TO YOUR APPLICATION THAT YOU THINK WE SHOULD KNOW ABOUT PLEASE GIVE DETAILS BELOW:

WHAT MACHINES ARE YOU QUALIFIED TO OPERATE?:

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WHAT LANGUAGES DO YOU SPEAK AND WITH WHAT FLUENCY?: SLIGHT FAIR FLUENT

ARE YOU A MEMBER OF ANY PROFESSIONAL ORGANISATION, OR UNDERTAKE ANY PUBLIC DUTIES?

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HOBBIES AND INTERESTS:

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PRE-EMPLOYMENT HEALTH QUESTIONNAIRE

PLEASE NOTE THAT THE AIM OF THIS QUESTIONNAIRE IS TO DECIDE WHETHER A MEDICAL EXAMINATION IS NECESSARY BEFORE YOU COMMENCE EMPLOYMENT. SOME JOBS, FOR EXAMPLE NIGHT WORK, LOCATIONS OR MEDICAL CONDITIONS REQUIRE INDIVIDUALS TO HAVE A MEDICAL EXAMINATION. IT IS RARE FOR MEDICAL CONDITIONS TO PRECLUDE EMPLOYMENT BUT FITNESS TO WORK MUST BE DETERMINED BY THE GROUP. THUS THE ACCURATE COMPLETION OF THIS QUESTIONNAIRE, TO THE BEST OF YOUR KNOWLEDGE AND BELIEF IS A CONDITION OF EMPLOYMENT WITH THE COMPANY. ACCORDINGLY, A DELIBERATE FAILURE TO GIVE FULL OR ACCURATE INFORMATION WILL NORMALLY LEAD TO TERMINATION OF EMPLOYMENT.

FULL NAME:

D.O.B.:

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING CONDITIONS?

	Yes	No
BLOOD DISORDERS FOR EXAMPLE HEPATITIS/HIV	<input type="checkbox"/>	<input type="checkbox"/>
DISEASES SUCH AS TYPHOID, CHOLERA, REOCCURRING DIARRHOEA	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PROBLEMS INCLUDING ASTHMA AND BRONCHITIS	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
EAR OR HEARING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
FITS, BLACKOUTS, REPEATED FAINTING OR EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>
HEART, BLOOD VESSEL PROBLEMS OR HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>
ANY MUSCLE WEAKNESS INCLUDING HERNIAS, ARTHRITIS AND BONE WEAKNESS	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY OR URINARY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
MENTAL ILLNESS INCLUDING ANXIETY AND DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>
ANY PREVIOUS NECK OR BACK PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
PROBLEMS WITH ALCOHOL CONSUMPTION OR DRUG DEPENDENCY	<input type="checkbox"/>	<input type="checkbox"/>
EYE PROBLEMS INCLUDING COLOUR BLINDNESS	<input type="checkbox"/>	<input type="checkbox"/>
SERIOUS SKIN COMPLAINTS OR ALLERGIES (INCLUDING DERMATITIS AND ALLERGIES TO DRUG/SUBSTANCES)	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE OR HAVE YOU EVER SUFFERED FROM A STRESS RELATED ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>
ANY CURRENT MEDICAL TREATMENT OR INVESTIGATION	<input type="checkbox"/>	<input type="checkbox"/>
ANY TIME OFF SICK IN THE LAST YEAR	<input type="checkbox"/>	<input type="checkbox"/>
STOMACH OR INTESTINAL DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>
DYSLEXIA	<input type="checkbox"/>	<input type="checkbox"/>
ANY CONDITION WHICH CAUSES SLEEP DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>
ANY REOCCURRING INJURIES/ILLNESS THAT WE SHOULD BE AWARE OF	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER BEEN REFUSED EMPLOYMENT OR DISMISSED ON MEDICAL GROUNDS	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU ANY PERMANENT DISABILITY	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU WITHIN THE PAST THREE YEARS, ATTENDED AN OUT-PATIENTS CLINIC OR HAD A COURSE OF TREATMENTS LASTING ONE MONTH OR MORE	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU SMOKE	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE, PLEASE GIVE FULL DETAILS INCLUDING DATES ON A SEPARATE SHEET

REFERENCES

PLEASE GIVE NAME, ADDRESS AND POSITION/OCCUPATION OF TWO REFEREES. ONE MUST BE YOUR MOST RECENT EMPLOYER. REFERENCES FROM FRIENDS/RELATIVES ARE NOT ACCEPTABLE.

NAME:

ADDRESS:

TELEPHONE:

TYPE OF REFERENCE - SCHOOL/COLLEGE/EMPLOYER/CHARACTER

NAME:

ADDRESS:

TELEPHONE:

TYPE OF REFERENCE - SCHOOL/COLLEGE/EMPLOYER/CHARACTER

GENERAL

HAVE YOU PREVIOUSLY WORKED FOR ANY OF THE COMPANIES WITHIN THE NIKE GROUP?: YES No

IF 'YES' PLEASE GIVE DETAILS

HAVE YOU APPLIED FOR A POSITION WITHIN THE NIKE GROUP BEFORE?: YES No

IF SO, WHAT POSITION?

HAVE YOU RELATIVES WORKING FOR THE NIKE GROUP?: YES No

NAME(S)

RELATIONSHIP

COMPANY NAME

FOR NON-BRITISH AND NON-EU NATIONALS

DATE OF ENTRY INTO U.K.?:

DATE OF EXPIRY?:

DO YOU HAVE A WORK PERMIT?: YES No

PLEASE GIVE TYPE OF WORK PERMIT:

DO YOU HAVE A RESIDENCY PERMIT?:

DATE OF EXPIRY?:

ETHNIC ORIGIN

TO ASSIST US IN MONITORING OUR EQUAL OPPORTUNITIES POLICY WE WOULD ASK YOU TO TICK THE APPROPRIATE BOX BELOW:

WHITE EUROPEAN WHITE OTHER BLACK CARIBBEAN BLACK AFRICAN BLACK OTHER INDIAN

PAKISTANI BANGLADESHI CHINESE OTHER NOT KNOWN

DECLARATION

BY SIGNING AND RETURNING THIS APPLICATION FORM YOU CONSENT TO THE NIKE GROUP OF COMPANIES USING AND KEEPING INFORMATION ABOUT YOU PROVIDED BY YOU - OR THIRD PARTIES SUCH AS REFEREES - RELATING TO YOUR APPLICATION OR FUTURE EMPLOYMENT. THIS INFORMATION WILL BE USED SOLELY IN THE RECRUITMENT PROCESS. I CONFIRM THAT I AM ELIGIBLE TO WORK IN THE UNITED KINGDOM. TO THE BEST OF MY KNOWLEDGE AND BELIEF THE PARTICULARS I HAVE GIVEN ARE TRUE. I UNDERSTAND THAT ANY FALSE STATEMENT MAY DISQUALIFY ME FROM EMPLOYMENT OR RENDER ME LIABLE TO DISCIPLINARY PROCEEDINGS WHICH COULD LEAD TO DISMISSAL

I ALSO UNDERSTAND THAT NO OFFER OF EMPLOYMENT MADE TO ME WILL BE BINDING UNLESS CONFIRMED IN WRITING.

SIGNATURE

DATE

Application for Employment



the Coppid Beech

JOHN NIKE WAY BRACKNELL BERKSHIRE RG12 8TF

TEL 01344 789799 FAX 01344 789798

E-MAIL ADDRESS: hr@nikegroup.co.uk WEB ADDRESS: www.coppidbeech.com

IF YOU WISH
YOU MAY
ATTACH A
RECENT PHOTO

THE INFORMATION WHICH YOU GIVE ON THIS FORM WILL BE TREATED AS **STRICTLY CONFIDENTIAL** AND ALL OR PART OF IT MAY BE CONTAINED IN A COMPUTERISED SYSTEM IN WHICH CASE THE REQUIREMENTS OF THE DATA PROTECTION ACT WILL BE COMPLIED WITH FULLY.

THE COMPANY IS AN EQUAL OPPORTUNITIES EMPLOYER.

GENERAL INFORMATION

POSITION REQUIRED:

HOW DID YOU HEAR OF THIS VACANCY:

PREFERENCE FOR: FULL TIME PART TIME
CASUAL

DATE AVAILABLE: SALARY EXPECTED:

NOTICE PERIOD FOR CURRENT EMPLOYER:

PERSONAL DETAILS

SURNAME: Mr / Mrs / Miss / Ms

FIRST NAMES:

PREVIOUS NAME:

ADDRESS:

POSTCODE:

HOME TEL NO:

EMAIL ADDRESS:

PART TIME APPLICANTS ONLY

HOW MANY HOURS A WEEK WOULD YOU LIKE TO WORK?

PLEASE INDICATE WHEN YOU WOULD BE WILLING TO WORK

	SUN	MON	TUES	WED	THUR	FRI	SAT
Day							
Evening							

MOBILE TEL NO:

NATIONALITY:

HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENCE WHICH IS NOT SPENT?: Yes No If 'YES' THEN GIVE DETAILS UNDER THE REHABILITATION OF OFFENDERS ACT 1974

DO YOU HAVE A CURRENT DRIVING LICENCE?: Yes No HOW MANY POINTS ARE ON YOUR DRIVING LICENCE?

DO YOU OWN A CAR?: Yes No

EDUCATION AND QUALIFICATIONS

NAME AND ADDRESS OF SCHOOL, UNIVERSITY, COLLEGE ATTENDED:-

FROM: To:

SUBJECT AREA AND QUALIFICATIONS:

NAME AND ADDRESS OF SCHOOL, UNIVERSITY, COLLEGE ATTENDED:-

FROM: To:

SUBJECT AREA AND QUALIFICATIONS:

NAME AND ADDRESS OF SCHOOL, UNIVERSITY, COLLEGE ATTENDED:-

FROM: To:

SUBJECT AREA AND QUALIFICATIONS:

**Please scroll to page one
to view your pdf proof.**