

APPLICATION FORM FOR OFFICE  
PROSPECTIVE EMPLOYEES

S Cartwright & Sons (Coachbuilders) Ltd  
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Note: This form is for permanent employees as well as agency employees who are taken on with a view to being permanent employees following their trial period.

POSITION APPLIED FOR:
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NAME:	SEX: MALE / FEMALE
ADDRESS:	NATIONALITY:
	HEIGHT:
	WEIGHT:
POSTCODE	
TELEPHONE NUMBER:	MOBILE NUMBER:
CURRENT DRIVING LICENCE:	
DETAILS OF ANY ENDORSEMENTS:	NATIONAL INSURANCE NO:
	GENERAL PRACTITIONER:

EDUCATION	
SCHOOLS ATTENDED:	QUALIFICATIONS GAINED

COLLEGE / UNIVERSITY	QUALIFICATIONS GAINED

OTHER TRAINING INC ANY HEALTH & SAFETY TRAINING	QUALIFICATIONS GAINED

PREVIOUS EMPLOYMENT:
NAME AND ADDRESS OF COMPANY:
POSITION HELD:
DUTIES:
REASON FOR LEAVING:

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REASON FOR LEAVING:

DOES THE EMPLOYMENT POSITION APPLIED FOR HAVE SIMILARITIES WITH PREVIOUS EMPLOYMENT YOU HAVE UNDERTAKEN? <span style="float: right;">YES <input type="checkbox"/> NO <input type="checkbox"/></span>
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CRIMINAL RECORD
PLEASE NOTE ANY CRIMINAL CONVICTIONS EXCEPT THOSE 'SPENT' UNDER THE REHABILITATION OF OFFENDERS ACT 1974. IF NON, PLEASE STATE:

REFERENCES: (PLEASE GIVE DETAILS OF TWO PERSONS FROM WHOM WE MAY OBTAIN BOTH CHARACTER AND WORK EXPERIENCE REFERENCES)
NAME: <span style="margin-left: 200px;">NAME:</span>
ADDRESS: <span style="margin-left: 200px;">ADDRESS:</span>
TELEPHONE NUMBER: <span style="margin-left: 200px;">TELEPHONE NUMBER:</span>

ARE YOU CURRENTLY A MEMBER OF A TRADE UNION? YES  NO

IF YES WHICH ONE?

HOW MANY YEARS HAVE YOU BEEN A MEMBER OF THIS TRADE UNION?

DO YOU SUFFER FROM DYSLEXIA YES  NO

PLEASE LIST ALL ABSENCES FROM WORK IN THE PAST 12 MONTHS AND THE REASONS FOR SUCH ABSENCES:

HAVE YOU EVER BEEN EMPLOYED BY THIS COMPANY OR ANY ASSOCIATED YES  NO

CARTWRIGHT COMPANY BEFORE? \_\_\_\_\_

IF SO, PLEASE GIVE DETAILS. \_\_\_\_\_

**LEISURE**

PLEASE NOTE HERE YOUR LEISURE INTERESTS, SPORTS AND HOBBIES, OTHER PASTIMES ETC

\_\_\_\_\_

\_\_\_\_\_

<b>MEDICAL DETAILS (PLEASE TICK )</b>		
Do you have any physical disability?	YES	NO
Are you registered disabled?	YES	NO
Is your eyesight good?	YES	NO
Do you wear glasses / contact lenses?	YES	NO
Do you have hearing problems?	YES	NO
Do you need a hearing aid or special facilities?	YES	NO
Have you ever had a fit or a blackout?	YES	NO
If so, is the problem controlled by drugs?	YES	NO
Are you currently taking drugs?	YES	NO
When did you last have a fit or blackout?		
Do they happen when you are awake or asleep?		
Are you allergic to anything?	YES	NO
If so, what?		
Have you ever suffered from a skin complaint such as eczema or dermatitis?	YES	NO
Are you a diabetic?	YES	NO
If so, how is it controlled?		

Do you have back trouble?	YES	NO
If so, have you been told not to lift weights, or not to stand or sit for long periods?	YES	NO
Do you have heart trouble?	YES	NO
Are you presently taking drugs or medicines or having treatment from your own doctor or hospital?	YES	NO
Have you ever had a tetanus injection? If yes, when was the last one?	YES	NO
Do you have any problems relating to alcohol dependency? If so please give details		
Do you have any problems relating to drug dependency? If so please give details		
Do you have any problems relating to stress-related issues? If so please give details		

<b><u>MEDICAL CONDITIONS</u> (PLEASE TICK OR COMPLETE APPROPRIATE BOX) HAVE YOU EVER SUFFERED OR DO YOU SUFFER WITH ANY OF THE FOLLOWING:</b>	<b>YES</b>	<b>NO</b>	<b>IF YES PLEASE STATE HOW YOU ARE CURRENTLY AFFECTED AND WHAT IF ANY MEDICATION OR IF TREATMENT IS USED</b>
Childhood Asthma Asthma of recent onset Hay Fever Bronchitis Chest Injury Chest Operation Pleurisy Tuberculosis Other Chest Conditions Redness or itching of the hands Numbness, Tingling or Blanching of the fingers Abnormal Colour Vision			

<b>SMOKING</b>	<b>YES</b>	<b>NO</b>
1.HAVE YOU EVER SMOKED? IF NO GO TO DECLARATION		
2. DO YOU SMOKE AT PRESENT?		
3. STATE AGE WHEN YOU FIRST STARTED SMOKING?		
4. IF YOU DO NOT SMOKE NOW STATE AT WHAT AGE YOU STOPPED		
5. HOW MANY MANUFACTURED CIGARETTES DO YOU USUALLY SMOKE OR WERE YOU SMOKING PER DAY?		

6. HOW MUCH TOBACCO DO YOU SMOKE OR WERE YOU SMOKING PER DAY? 1 OZ = 30G		
7. DO YOU SMOKE OR WERE YOU SMOKING A PIPE?		
8. HOW MANY SMALL CIGARS DO YOU SMOKE OR WERE YOU SMOKING PER DAY?		
9. HOW MANY LARGE CIGARS DO YOU SMOKE OR WERE YOU SMOKING PER DAY?		

DECLARATION: I DECLARE THAT THE ABOVE ANSWERS ARE TRUE AND CORRECT. IF ANY FALSE OR MISLEADING INFORMATION IS PROVIDED, THE COMPANY RESERVE'S THE RIGHT TO WITHDRAW, AT ANY TIME, YOUR EMPLOYMENT.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

<b>DEPARTMENT MANAGERS APPROVAL OF EMPLOYMENT</b>	<b>YES</b>	<b>NO</b>
<b>SIGNATURE:</b>		
<b>PRINT:</b>		

<b>H &amp; S MANAGERS APPROVAL OF EMPLOYMENT</b>	<b>YES</b>	<b>NO</b>
<b>SIGNATURE:</b>		
<b>PRINT:</b>		

<b>DIRECTORS APPROVAL OF EMPLOYMENT</b>	<b>YES</b>	<b>NO</b>
<b>SIGNATURE:</b>		
<b>PRINT:</b>		