Application for Employment

Kindly submit your application by faxing it to the fax number as indicated on the relevant advertisement.

Correct information will be a condition of employment.
Please note that we regret that submission of a CV without completing this form is not acceptable.

Date

Job Title
Reference number

PERSONAL DETAILS

Surname	Initials	Title
First Names		
Postal address	Residential Address	
Postal code	Postal code	
Email Address		
Telephone (Private)	Telephone (Business)	
ID number	Passport Number	
Date of Birth	Passport Expiry Date	
Gender	Nationality	
Tax Number	Marital Status	

EDUCATION AND TRAINING

Secondary Education
Years Attended
Examination Results

Tertiary Education Qualification
Institution Name
Years Attended
Course Results

Other Tertiary Education Qualification
Institution Name
Years Attended
Course Results

PREVIOUS EMPLOYMENT

Employer
Type of business
Address
Position held
Type of responsibilities
Salary
Reason for leaving

Application for Employment

Employer
Type of business
Address
Position held
Type of responsibilities
Salary
Reason for leaving

MEDICAL HISTORY

General	Yes	No
Are you currently taking any medication or treatment requiring a strict timetable?		
Have you in the past received compensation for any industrial injury or illness?		
Have you ever had an illness/accident that caused you to be absent from work for more than 3 months?		
Have you been absent from work for any medical reason for more than 10 days in the past year?		
Have you ever had to give up any previous job for medical reasons?		
Do you wear glasses/contact lenses?		
Have you in the past been involved in an aircraft related accident		

Have you been exposed to any of the following hazards?	Yes	No		Yes	No
Lead			Chemicals		
Vibration			Excessive Noise		
Tar			Excessive Dust/Fumes		
Radiation			Compressed Air Conditions		
Asbestos			Other (please specify)		

Have you ever suffered from any of the following?	Yes	No		Yes	No
Heart Disease			Deafness		
Blood Pressure			Asthma		
Back Pain			Poor Vision		
Psoriasis			Abdominal Complaint		
Eczema			Urinary Disorder		
Migraine			Seizures/Blackouts		
Allergies			Stomach Ulcer		
Lung Disease			Ear Disease		
Jaundice			Eye Disease		
Joint Pain			Kidney Disease		
Diabetes			Other (please specify)		

I confirm that the above information is true and correct.

Print name: _____ Signature: _____ Date: _____