



CALVARY HEALTH CARE RIVERINA

Calvary Health Care Riverina is a fully accredited, 104 bed licensed, acute care private hospital in the Riverina and forms an integral part of the National Health Care Services of the Sisters of the Little Company of Mary.

At Calvary we express our “Being for Others” through respect for the individual and an understanding of the healing power of caring. Our aim is to promote the physical and spiritual wellbeing of all people involved in and with our health care facility.

EMPLOYMENT APPLICATION

Instructions for completion of employment application:

1. Please complete **all areas** of the application form, including Confidential Immunisation Status Questionnaire.
2. Please also attach the following documentation:
 - covering letter addressing relevant criteria (if advertised) for the position you are applying for.
 - current Resume/Curriculum Vitae.
 - certified copy of your current NSW Nurses Registration (if applicable).



*Venerable Mary Potter
Mother Foundress, Little Company of Mary*

MISSION

Our Mission identifies why we exist:
We bring We bring the healing ministry of Jesus to those who are sick, dying, and in need through “being for others”:

- In the Spirit of Mary standing by her Son on Calvary;
- Through the provision of quality, responsive and compassionate health and aged care services;
- Based on Gospel values; and
- In celebration of the rich heritage and story of the Sisters of the Little Company of Mary.

VISION

As a Catholic Health, Community and Aged Care provider, to excel, and be recognised, as a continuing source of healing, hope and nurturing to the people and communities we serve.

VALUES

As stewards of the rich heritage of care and compassion of the Little Company of Mary, we are guided by our values:

- ⊙ **hospitality:** demonstrates our response to the desire to be **welcomed**, to feel wanted and to belong. It is our responsibility to extend this to all who come into contact with our services by promoting connectedness and listening and responding openly.
- ⊙ **healing:** demonstrates our desire to respond to the **whole person** by caring for their spiritual, psychological and physical well being. It is our responsibility to value and consider the whole person and to promote healing through reconnecting, reconciling and building relationships.
- ⊙ **stewardship:** recognises that as individuals and as a community all we have has been given to us as a **gift**. It is our responsibility to manage these precious resources effectively for the future. We are responsible for: striving for excellence, developing personal talents, material possessions, our environment, and handing on the mission of the Sisters of the Little Company of Mary.
- ⊙ **respect:** recognises the **value** and **dignity** of every person who is associated with our services. It is our responsibility to care for all with whom we come into contact with justice and compassion no matter what the circumstances, and we are prepared to stand up for what we believe and challenge behaviour which is contrary to our values.

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How did you hear about this
position? _____

Date: _____

Position applied for: _____

Full Time Part Time Casual

Surname: _____ Other Names: _____

Title: (please tick) Mr Mrs Miss Ms

Postal address: _____

Telephone Number: () _____ Mobile: _____

Are you an Australian citizen? yes No Date of Birth: _____
(Optional)

(if no please list work visa details, dates etc) _____

Next of Kin : _____ Relationship _____

Next of Kin Contact Telephone Number: () _____ Mobile: _____

NSW Nurses Registration No. (Nursing Only - please attach certified copy) _____ Expiry: _____

Education and Training

*(Instead of filling out this section, you can attach a copy of your resume that **completely** answers these questions)*

Education – Secondary	Dates attended (years)	Qualifications obtained
Education – Technical, etc	Dates attended	Qualifications obtained
Education – University, College etc	Dates attended	Qualifications obtained

(It is important that you photocopy and attach all details of further education as relevant)

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Professional or Other Training	Dates Attended	Qualifications Obtained

(You should photocopy and attach details of further training as relevant)

Please list any awards you have received (school, community, citizenship, etc)

Do you speak any other languages? If so please tell us the language and state your fluency.

Employment History

*(Instead of filling out this section, you can attach a copy of your resume that **completely** answers these questions.)*

(Starting with your most recent employment)

Date: from – to	Employer and Type of Business	Position Held	Main Duties	Reason for Leaving

(You should attach details of all previous employment)

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Work Experience

Date: from - to	Employer and Type of Business	Position Held and Details of Main Duties

About Yourself

What are your main hobbies, interests, etc. outside of work?

*(Instead of filling out this section, you can attach a copy of your resume that **completely** answers these questions)*

Volunteer Work

Date: from – to	Employer and Type of Business	Position Held and Details of Main Duties

Are you a member of any professional associations? Please list them and your joining date.

Driver's Licence: (please tick) yes no

class _____ state of issue _____

Please list any other licences or accreditations you hold.

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Medical History

Do you have any health problems or medical condition which may affect your ability to perform the requirements of this position as specified in the position description attached to this application?

yes no

If so, please provide details

Calvary Health Care Riverina may require you to undertake a medical examination as a condition of employment. Such an examination would be at our expense.

Are you willing to undergo such an examination? yes no

Do you know of any reason why, if appointed, you would be unable to attend regularly for work? yes no

If so, please give details:

What value would you expect to add to our service if we were to employ you?

(please be descriptive)

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References

It is important that you give the names, addresses and telephone numbers of three **professional** referees whom we can approach **now** for a reference. We would prefer to contact current or previous employers. Your referee should be from your working history, not personal reference.

1.

Referee's Name		
Company		
Position		
Address		
Town / City		Postcode
Telephone		

2.

Referee's Name		
Company		
Position		
Address		
Town / City		Postcode
Telephone		

3.

Referee's Name		
Company		
Position		
Address		
Town / City		Postcode
Telephone		

Please give the date that you could commence employment : _____

I understand that any false or misleading information given in this application may render my contract of employment, if I am appointed, liable to termination. I declare that to the best of my knowledge, the above information and that submitted in any accompanying document(s) is true and correct. I understand that you will be contacting my referees, without discussion with me, for a detailed reference.

Signature of applicant : _____ Date : _____

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OFFICE USE ONLY

Application received :

Date	Time	Action / Comments

Interview Held & interview sheets attached:

Date	Time	Interviewers Comments / Action

Reference Checks completed & attached:

Date	Comments
1.	
2.	

To Executive Member for review and approval:

Date	Comments

Commencement Details:

Appropriate for Position : yes no

Appointed : yes no

Status : Casual PPT Full Time

hospital orientation (non-clinical) _____

clinical orientation _____

appointment letter sent _____

CONFIDENTIAL IMMUNISATION STATUS QUESTIONNAIRE

Surname:	First Name:
Date of Birth:	Position & Staff Category:
Ward / Dept:	Contact No:

Calvary Health Care Riverina (CHCR) is committed to providing a safe working environment for employees, including volunteers. CHCR is required to record each employee's (i) immunity status; and (ii) their acceptance or refusal of vaccine. This will enable CHCR to have an effective system for ensuring employees have an appropriate level of immunity; and comply with the requirements of NSW Health Policy Directive PD2007_006 Occupational Assessment, Screening & Vaccination Against Specified Infectious Diseases. **Staff must comply with the assessment, screening and vaccination requirements of this policy. Staff who do not consent to assessment, screening and vaccination must acknowledge this in writing (Section 3)**

There are 2 employee categories.

Category A - contact with clients or contact with blood, body substances or infectious material; clinical staff.

Category B - no contact with clients; blood, body substances or infectious material; and who are not deployed to clinical areas and have no greater exposure to infectious diseases than the general public.

Protection / TB Screening Required by Risk Category		
Infectious Disease	Risk Categories	
	A	B
<i>Diphtheria, tetanus, pertussis (whooping cough)</i>	Y	R
<i>Hepatitis B</i>	Y	N
<i>Measles, mumps, rubella</i>	Y	R
<i>Tuberculosis</i>	Y	N
<i>Varicella (chickenpox)</i>	Y	R
<i>Influenza</i>	R (annual)	R (annual)

Key:

Y = Protection/TB screening required

N = Protection/TB screening not routinely required

R = Vaccines recommended for the general population

The immunisation details you provide will be entered into a confidential database and kept in a secure location. The database will enable CHCR to provide you with:

- A record of your vaccination / immune status, during/at termination of employment
- Reminders for overdue or booster doses; and/or
- Reminders for due dates for immune status checks.

All employees must provide documented medical evidence of their immunity status of the following:

- **Diphtheria / tetanus / pertussis (whooping cough);**
- **Hepatitis B;**
- **Measles / mumps / rubella;**
- **Tuberculosis;**
- **Varicella (chickenpox).**

Hepatitis A vaccination is recommended for Maintenance staff

All employees are required to **complete Section 1** below relating to latex allergies. The CHCR Staff Health Programme includes an immunisation programme.

Vaccinations are available, free of charge, to all CHCR employees.

If you **wish to participate** in the immunisation programme, please **complete Section 2**.

If you **DO NOT wish to participate** in the immunisation programme please **complete the disclaimer in Section 3**.

SECTION 1: Latex information (All employees to complete)

Please for any YES answer(s) and give details

Do you or your immediate family suffer from:

- Allergies Asthma Eczema Hay fever Hives (urticaria) Allergic conjunctivitis / rhinitis
 Unexplained rash

Have you ever had a skin reaction after using:

- Band-aids Elastoplast / sticking plaster Clothing with elastic (bras, underpants)

Have you noticed any reaction after using / handling:

- Balloons Rubber gloves Condoms or diaphragms Urine catheter

After a visit to the dentist have you noticed:

- Itching Sneezing Running nose

Have you ever had a reaction after eating:

- Avocado Bananas Kiwi Fruit Chestnuts
 Other foods (give details):

Also ...

- Have you ever been diagnosed with latex allergies? Does your work entail the use of latex gloves?
 Have you ever had multiple operations in your life?

SECTION 2: Immunisation and Screening (employees wishing to participate)

a. Diphtheria / tetanus / pertussis	Had vaccination?	Yes / No / Unsure Batch no;
b. Tetanus	Had vaccination?	Yes / No / Unsure Year last vaccinated:
c. Hepatitis A	Had vaccination?	Yes / No / Unsure Year last vaccinated: Batch no;
d. Hepatitis B	Vaccinations?	
	1. Commenced Hep B course	Yes / No / Unsure
	2. 1 st injection	Date and batch no.:
	3. 2 nd injection	Date and batch no:
	4. 3 rd injection	Date and batch no:
	5. Titre level	Hep B surface Ab;
	6. Reason not vaccinated	Please outline:
e. Measles / Mumps / Rubella	Had vaccination?	Yes / No / Unsure Year last vaccinated:
f. Tuberculosis	TB History	
	1. BCG vaccination	Yes / No / Unsure
	2. TB history	Yes / No / Unsure
	Treatment History	
	1. Mantoux test	Yes / No / Unsure Year of test & result:
	2. Chest x-ray taken	Yes / No Year of x-ray:
g. Varicella (chickenpox)	1. Had vaccination?	Yes / No / Unsure Year last vaccinated:
	2. Varicella history	Yes / No / Unsure
All specified infectious diseases (a - g) as outlined above	<i>Documented medical evidence provided to Infection Control Co-Ordinator</i>	Yes / No

Influenza	<i>Do you wish to receive annual influenza vaccine?</i>	Yes / No
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I certify that the information outlined above is correct and I choose to take part in the immunisation programme.

Signature:	Date:
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SECTION 3: <u>TUBERCULOSIS (TB) SCREENING RECORD</u>			
SURNAME:		DOB:	
FIRST NAMES:		SEX:	
ADDRESS:			
			POST CODE:
TELEPHONE:			
COUNTRY OF BIRTH:		PARENTS COUNTRY OF BIRTH:	
REASON FOR SCREENING: PRE EMPLOYMENT ROUTINE CONTACT (PLEASE CIRCLE)			
POSITION:		Local GP:	
MEDICAL HISTORY:		TB RISKS:	
Have you had any of the following? Please circle YES or NO :			
Any immune suppressive illness	YES/NO	Cough: Non-productive	YES/NO
Known Allergies	YES/NO	Cough: Productive	YES/NO
Chest Illnesses	YES/NO	Unexplained Weight Loss	YES/NO
Are you taking any		Fever/Chills	YES/NO
tablets/medication	YES/NO	Night Sweats	YES/NO
Have you had a Live Vaccine or		Hemoptysis	YES/NO
Viral illness in the last 4 weeks?	YES/NO	Fatigue/Weakness	YES/NO
Smoker?	YES/NO	Anorexia (loss of appetite)	YES/NO
		Previous treatment for TB	YES/NO
		Vaccination for TB BCG	YES/NO
		If yes, where and when	Year:
<i>You can provide this information</i>		Family history of TB	YES/NO
<i>in private with a Clinician if you</i>		Known contact with TB	YES/NO
<i>wish</i>		Worked in HIGH TB Risk Areas	YES/NO
		Lived/worked in High TB Risk Countries	YES/NO
<p>If you have answered YES to any of the questions above, please give details : For overseas countries list the places and length of stay for last 5 years:</p>			
List where you have worked in health related positions for the last 5yrs:			

SECTION 4: Immunisation and Screening Disclaimer (employees not wishing to participate)

*I am aware that I have an obligation to cooperate with the CHCR Staff Health Program as required by the DoH Policy Directive PD2007_006 Occupational Assessment, Screening and & Vaccination Against Specified Infectious Diseases, but choose **NOT** to participate in the immunisation programme as outlined below.*

I am aware of the potential risks my non-participation in assessment, screening and/or vaccination may pose and that non-participation will require CHCR to manage me as an unprotected / unscreened employee and may apply work restrictions as applicable under the Policy.

*I decline to:
(tick box for those declined)*

- Participate in assessment / vaccination for diphtheria / tetanus / pertussis (dTpa)
(circle applicable)
- Participate in assessment / vaccination for hepatitis A
(circle applicable)
- Participate in assessment / vaccination for hepatitis B
(circle applicable)
- Participate in assessment / vaccination for measles / mumps / rubella (MMR)
(circle applicable)
- Participate in screening for tuberculosis
- Participate in assessment / vaccination for varicella
(circle applicable)

However, I am aware that I MUST provide documented medical evidence of my immunisation status to the Infection Control Manager.

Signature:

Date:

Thank you.

If you have any queries please contact the Staff Health Coordinator (02)69253055 (Ext 281).