



Private and Confidential

APPLICATION FORM

POSITION APPLIED FOR: _____

JOB REFERENCE NUMBER: _____

CLOSING DATE: _____

Please complete all sections of this application form and submit to:

**The Human Resources Department
Clear Pharmacy
7 Thalia Street
Donegall Road
Belfast
BT12 5PT**

OFFICE USE ONLY

Name of Applicant:

Short Listed

Not Short Listed

Date Application Received:

HUMAN RESOURCES DEPARTMENT

All candidates are considered strictly on their merits in relation to the selection criteria for the job. It is our policy not to discriminate on grounds of sex, marital status, age, race, colour, nationality, ethnic or national origins, sexual orientation, disability or religious or political affiliation.

PERSONAL PARTICULARS (Please use BLOCK capitals)

Surname:	Mr/Mrs/Miss/Ms	First Names:
Address:	Postcode:	Telephone No:
		Work No:
		Mobile No:
		Email Address:

Have you ever been employed by this Company before? **YES/NO**

If YES, please provide details of dates employed and position(s) held:

Are you willing to work overtime and weekends when required? **YES/NO**

Do you have any commitments which might limit your working hours or cause difficulties when required to work overtime or weekends? **YES/NO**

If YES, please provide details:

Are you subject to any restraints on your current or future employment? **YES/NO**

If YES, please provide details:

Please detail Membership(s) Grade(s) of Professional Institutions:

Please detail any experience, skills or achievements that you feel may be relevant in your application for employment:

EDUCATION – Please use an additional sheet if necessary. CANDIDATES MUST CLEARLY OUTLINE ON THEIR APPLICATION FORMS THAT THEIR QUALIFICATIONS MEET EACH OF THE ESSENTIAL AND PREFERRED CRITERIA OUTLINED IN THE ADVERTISEMENT.

SECONDARY SCHOOL(S)/COLLEGES	SUBJECTS TAKEN WITH RESULTS OBTAINED/EXPECTED		
	LEVEL	SUBJECT	GRADE
FURTHER EDUCATION	SUBJECTS STUDIED		RESULTS OBTAINED/EXPECTED
POST GRADUATE QUALIFICATION	SUBJECTS STUDIED		RESULTS OBTAINED/EXPECTED

Technical, Professional, Occupational Training

(include apprenticeships, evening/day release courses and company courses)

COLLEGE/COMPANY/INSTITUTE	TRAINING UNDERTAKEN	QUALIFICATIONS GAINED

**EMPLOYMENT RECORD – Please list your previous posts, beginning with the most recent. Please use an additional sheet if necessary.
 CANDIDATES MUST CLEARLY OUTLINE ON THEIR APPLIUCATION FORMS HOW THEIR EXPERIENCE MEET EACH OF THE ESSENTIAL AND
 PREFERRED CRITERIA OUTLINED IN THE ADVERTISEMENT.**

DATES		NAME OF EMPLOYER, ADDRESS AND NATURE OF BUSINESS	POSITION & DUTIES	STARTING & LEAVING SALARY	REASON FOR LEAVING
From	To				
<p>Any other information you may wish to add:</p>					

ADDITIONAL INFORMATION

Have you ever been convicted of a criminal offence, in any country, as defined under the Rehabilitation of Offenders (NI) Orders 1978?		YES/NO
If YES, please give details:		
Current/most recent salary:		
Date of salary increase:	Date next increase due:	Bonuses payable:
Substantial fringe benefits: (including holiday entitlement):		
Length of notice:	When could you start work if appointed?	
Salary Range Expected:	Any other benefits expected?	

REFERENCES:

Please give the names and addresses of two employers (one of which should be a current employer) who can be approached for a reference (neither should be a relative).

<p>1. Name: _____</p> <p>Occupation: _____</p> <p>Company: _____</p> <p>Address: _____</p> <p>_____</p> <p>_____</p> <p>Telephone No: _____</p>	<p>2. Name: _____</p> <p>Occupation: _____</p> <p>Company: _____</p> <p>Address: _____</p> <p>_____</p> <p>_____</p> <p>Telephone No: _____</p>
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MEDICAL DECLARATION FORM - All applicants must complete this form

SURNAME: _____ OTHER NAMES: _____

ADDRESS: _____

NAME AND ADDRESS OF FAMILY DOCTOR

Please complete the following questions ticking the appropriate box. If the answer is yes to any question, please give of (1) Date; (2) Amount of time lost from work; (3) any treatment at present or planned for the future. Complete the questionnaire as fully as possible and continue on a separate sheet if necessary. The information will be treated in confidence. If information is withheld, suppressed or is deliberately misleading or false, you may be liable for dismissal.

	Have you had any of the following conditions in the last 12 months?		Previous to the last 12 months	
	Yes	No	Yes	No
A Fainting attacks or giddiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B Blackouts, epilepsy or fits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D Dermatitis, hand eczema or other skin disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E Heart trouble, heart attack or angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G Back, neck or any joint problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I Any form of diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J Sinusitis, discharging ears or hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K Any allergies:				
Penicillin/Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other - please specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L Are you colour blind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M Are you currently or have you recently, been taking drugs or medicines? If so, what for?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Declaration of Applicant.

I declare to the best of my knowledge the above statements are correct. I fully understand the warning given above and appreciate that a health interview may be necessary.

Signed: _____ Date: _____

We would like to assure you that the Company adheres to all relevant employment legislation and this information will be process accordingly.

Please complete the declaration below.

I hereby declare that the statements contained in this application form are, to the best of my knowledge, true and complete in every respect and that no material facts have been withheld, misrepresented or suppressed.

Signature: _____ **Date:** _____
