

# APPLICATION FORM

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**Fax** to 4141701 or **mail** to PO Box 100-455 NSMC or **scan/email** to [greg.howell@rapidlabels.co.nz](mailto:greg.howell@rapidlabels.co.nz)

**YOUR NAME**

**HOME ADDRESS**

**BEST PHONE NUMBER**

**EMAIL**

**POSITION APPLYING FOR**

**YOUR MOST RECENT POSITION**

**WHAT WORK EXPERIENCE MAKES YOU A SUITABLE CANDIDATE?**

**OTHER REASONS TO SHORTLIST YOU**

**QUESTIONS**

	YES	NO
Ever been employed by Rapid Labels or Blue Star Print Group before?	<input type="checkbox"/>	<input type="checkbox"/>
Are you happy for us to make enquiries with past/present employers?	<input type="checkbox"/>	<input type="checkbox"/>

**QUESTIONS**

	YES	NO
Are you a New Zealand Citizen?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a prosecution against you in the past or pending?	<input type="checkbox"/>	<input type="checkbox"/>
Have you a full and valid New Zealand Drivers Licence?	<input type="checkbox"/>	<input type="checkbox"/>

**MEDICAL**

HAVE YOU HAD?	YES	NO	WHEN	DO YOU SUFFER FROM?	YES	NO
Compensation for any injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Earache, deafness etc	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Dermatitis or Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Heart complaint	<input type="checkbox"/>	<input type="checkbox"/>
Back injury or strain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Injury to limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Sensitivity to chemicals	<input type="checkbox"/>	<input type="checkbox"/>
Blackouts/fits of any kind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Any Gradual Process Injury	<input type="checkbox"/>	<input type="checkbox"/>
Any Gradual Process Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Any allergies	<input type="checkbox"/>	<input type="checkbox"/>
Do you have normal vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Other ailments or diseases :		
Have you had corrected vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Do you have normal colour vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
Are you taking drugs or medicine?	<input type="checkbox"/>	<input type="checkbox"/>				

Details:

**DECLARATION**

I, \_\_\_\_\_ (full name) declare that to the best of my knowledge, that answers to the questions in this application are correct and I understand that if any false information is given, or any material fact suppressed, I may not be accepted, or if I am employed, I may be dismissed.

Date \_\_\_\_\_ Signature \_\_\_\_\_