Clear All

Job Application

PERSONAL INFORMATION

Name: _____ Date of Birth (dd-mmm-yyyy): _____

Street: _____ City: _____ Postal Code: _____

Phone: _____ Mobile: _____ Email: _____

Do you have a valid Driver's License? ☐ Yes ☐ No If yes, Driver's License #: _____

Education: _____

Position Applied for: _____ Expected Rate of Pay: _____

Relevant skills or qualifications: _____

Were you referred by a current employee? _____

Were you previously employed by Nelson? ☐ Yes ☐ No If Yes, When? _____

When will you be available for work? _____

PERSONAL REFERENCES

Name	Occupation	Phone
_____	_____	_____
_____	_____	_____

EMPLOYMENT HISTORY *(MOST RECENT FIRST)*

Company: _____ City: _____ Duration of Employment: _____

Contact: _____ Phone: _____ May we contact this employer: ☐ Yes ☐ No

Describe the work you did: _____

Reason for Leaving: _____

Company: _____ City: _____ Duration of Employment: _____

Contact: _____ Phone: _____ May we contact this employer: ☐ Yes ☐ No

Describe the work you did: _____

Reason for Leaving: _____

Company: _____ City: _____ Duration of Employment: _____

Contact: _____ Phone: _____ May we contact this employer: ☐ Yes ☐ No

Describe the work you did: _____

Reason for Leaving: _____

ACKNOWLEDGMENT

I duly declare the above information to be accurate and correct to the best of my knowledge. I understand that any omissions or misrepresentations may result in dismissal upon review by Nelson Roofing & Sheet Metal Ltd.

Signature: _____ Date: _____

(Individuals applying electronically will be asked to sign if interviewed)

MEDICAL INFORMATION
VOLUNTARY AND CONFIDENTIAL

1. Do you have a First Aid Ticket? ☐ Yes ☐ No If yes, level completed? _____
2. Do you have WHMIS training? ☐ Yes ☐ No If yes, when? _____
3. Do you have Fall Protection Training? ☐ Yes ☐ No Certificate # _____
4. Have you ever had a hearing problem? ☐ Yes ☐ No Date of last test? _____
5. Have you ever had a head injury? ☐ Yes ☐ No
6. Do you have Epilepsy? ☐ Yes ☐ No
7. Do you have dizzy or fainting spells? ☐ Yes ☐ No
8. Do you have Diabetes? ☐ Yes ☐ No
9. Have you ever had an eye injury? ☐ Yes ☐ No
10. Are you uncomfortable with heights? ☐ Yes ☐ No
11. Have you ever had a bone fracture? ☐ Yes ☐ No If yes, please specify. _____
12. Do you have Rheumatism or Arthritis? ☐ Yes ☐ No If yes, please specify. _____
13. Have you ever had an injury to a major joint? (e.g. Ankle, Knee, Hip, Elbow, Shoulder)
    ☐ Yes ☐ No
    If yes, please specify. _____
14. Do you have a heart condition? ☐ Yes ☐ No
15. Do you have High Blood Pressure? ☐ Yes ☐ No
16. Do you have allergies? ☐ Yes ☐ No If yes, to what? _____
17. Have you ever had a back problem? ☐ Yes ☐ No
    If yes, please explain. _____
18. Do you have any respiratory problems? ☐ Yes ☐ No
    If yes, what? _____
19. Do you have a hernia? ☐ Yes ☐ No
20. Are you taking any medications at the present time?
    ☐ Yes ☐ No
    If yes, what? _____
21. Have you seen a Physician for any illness, injury or surgery in the past year?
    ☐ Yes ☐ No
    If yes, what illness, injury or surgery? _____
22. Are you medically cleared and fit to work with no restrictions or disabilities from any previous occupational injury, illness or mental condition? ☐ Yes ☐ No
23. Is there any other pertinent medical, illness or injury related information you feel we should be aware of?
    ☐ Yes ☐ No
    If yes, please explain _____

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