



Employment Application

DATE:

FIRST NAME:

LAST NAME:

UNIT #:

STREET ADDRESS:

CITY:

PROVINCE:

POSTAL CODE:

PHONE:

SOCIAL INSURANCE NUMBER

DO YOU HAVE A VEHICLE: YES () NO ()

DATE OF BIRTH: DAY / MONTH / YEAR

Email:

IN THE SPACE PROVIDED BELOW, PLEASE LIST: Any tickets, qualifications or completed safety courses you have (i.e. WHIMS, St. John's Ambulance), or any other helpful information.

WORK REFERENCES:

EMPLOYER:

EMPLOYER:

SUPERVISOR

SUPERVISOR

PHONE:

PHONE:

EMAIL:

EMAIL:

Employment Application

MEDICAL EMERGENCY INFORMATION (CONFIDENTIAL): This medical information is requested for the purposes of assisting us in placing you within a work position suitable to your capacity and therefore minimizing the risk of serious injury to yourself, your fellow workers and/or the public.

1. Have you ever had a head injury? Yes ___ No ___
2. Do you have epilepsy? Yes ___ No ___
3. Do you have dizzy or fainting spells? Yes ___ No ___
4. Do you have diabetes? Yes ___ No ___
5. Have you ever had a hearing problem? Yes ___ No ___
6. Have you had a previous eye injury? Yes ___ No ___
7. Have you had any previous fractures? Yes ___ No ___
8. Have you had a previous injury to any major joints?
i.e. ankle, knee, hip, elbow, shoulder? Yes ___ No ___
9. Do you have a heart condition? Yes ___ No ___
10. Do you have high blood pressure? Yes ___ No ___
11. Do you have any allergies? Yes ___ No ___
If yes, please specify: _____
12. Have you ever had any back problems? Yes ___ No ___
13. Do you have any respiratory problems? Yes ___ No ___
If yes, please specify: _____
14. Do you have a hernia? Yes ___ No ___
If yes, please specify: _____
15. Are you taking medications at present time? Yes ___ No ___
If yes, please specify: _____

16. Have you seen a physician for any illness, injury or surgery in the past year? Yes ___ No ___
Illness: _____
Injury: _____
Surgery: _____
Silicosis Test: _____

17. Are you medically cleared and fit to work with no restrictions or disabilities from any previous occupational injury, illness or medical condition? Yes ___ No ___

18. Is there any other pertinent medical illness or injury related information you feel we should be aware of? Yes ___ No ___
If yes, please specify: _____

19. Are you bondable? Yes ___ No ___

I the undersigned, 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 reclassification or dismissal upon review by my employer. I further authorize my employer to obtain a medical evaluation by a physician if required.

Employees Signature: _____

By checking this box you, the applicant, are providing Agile Staffing with consent to conduct a criminal background check on the name(s) you have provided on this employment application.

Please send complete application to info@agilestaffing.ca