

# PERSONAL DETAILS FORM

---

## PERSONAL DETAILS

Surname:

Dr / Mrs / Ms / Miss / Mr

Given Name/s:

Preferred Name:

Date of Birth:

---

## CONTACT DETAILS

Residential Address:

Suburb:

Post Code:

Postal Address:

Suburb:

Post Code:

Phone Number:

Home:

Mobile:

Preferred Contact Number:

Email Address:

---

## EQUAL EMPLOYMENT OPPORTUNITY

Completion of this section is voluntary; however, your co-operation would be appreciated.

This section is for compliance with EEO legislation only.

Country of birth:

Nationality:

We embrace diversity and strongly encourage application from Indigenous Australian and people from culturally and linguistically diverse backgrounds.

Are you an Aboriginal Person?

☐ Yes / ☐ No

# PERSONAL DETAILS FORM

Are you a Torres Strait Islander Person?

☐ Yes / ☐ No

It is policy of St John of God Health Care to welcome applications from people with disabilities and to attempt to meet reasonable / appropriate work-related requirements of employees.

Do you have a Disability?

☐ Yes / ☐ No

Additional information if required: