# Employee Details Form.

## This form provides information for Now Actually to save and retained on your personal file.

All information is confidential.

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| **Your Details** | |
| **Name** |  |
| **Phone Number** |  |
| **Address** |  |
| **Email** |  |
| **DOB** |  |
| **Visa Status** |  |
| **Next Of Kin** | |
| **Name** |  |
| **Phone Number** |  |
| **Address** |  |
| **Relationship** |  |
| **Secondary Next of Kin** | |
| **Name** |  |
| **Phone Number** |  |
| **Address** |  |
| **Relationship** |  |
| **Bank Details** | |
| **Bank** |  |
| **Account Name** |  |
| **BSB Number** |  |
| **Account Number** |  |

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| **Doctor Details** | |
| **DR Name** |  |
| **Clinic** |  |
| **Phone Number** |  |
| **Address** |  |
| **Health & Wellbeing Declaration** | |
| Health and wellbeing is important to Now Actually. Your safety is our number one priority. As part of being employed with Now Actually, you are required to declare information which assists the company in making decisions by ensuring that no person is placed in an environment or given tasks that will result in physical or mental harm.  **Please complete all sections of this declaration.**  We may disclose some of your personal information, as applicable; to an independent medical examiner should we require an assessment of your suitability for employment and fitness for duty; however, we will speak to you prior to doing this. Your declaration may be also disclosed to our WorkCover insurer should you submit a WorkCover claim for compensation. | |
| **Do you have any injuries, illness or conditions that we should be aware of and/or may impact your performance in your position?** | |
| Yes  No | |
| If you answered yes, please provide details below to ensure that we do not put place you in a position that may negativity impact you. | |
|  | |
| **In the last 2 years have you had a significant injury or illness that resulted in time off from the workplace?** | |
| Yes  No | |
| If you answered yes, please provide details below to ensure that we do not put place you in a position that may negativity impact you. | |
|  | |
| **Is there any other medical information the Company needs to be aware of?** | |
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| **Sign Off** | |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, confirm that the information I have provided on this form and declaration is correct and I have disclosed all the relevant information required.  I acknowledge and consent to the Company collecting the above information for the purposes of my employment with the Company.  I acknowledge that without the above information the Company will not be able to comply with all its legal obligations to me. | |
| **Signature** |  |
| **Date** |  |