**SECTION 1 | To be completed by ALL personnel including work experience, work trial and volunteers**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Information** | | | | | | | | | | | |
| Full Name |  | | | | | | | | | | |
| Address |  | | | | Suburb | |  | | | Post Code |  |
| Home Phone |  | | | | Mobile Phone | | | | |  | |
| E-mail Address |  | | | | Date of birth | | | | |  | |
| Tax File Number |  | | | | | | | | | | |
| **Emergency Contact Information** | | | | | | | | | | | |
| **Emergency Contact 1** | | | | **Emergency Contact 2** | | | | | | | |
| Full Name |  | | | Full Name | | | |  | | | |
| Relationship |  | | | Relationship | | | |  | | | |
| Address |  | | | Address | | | |  | | | |
| Suburb & Post Code |  | | | Suburb & Post Code | | | |  | | | |
| Contact Phone |  | | | Contact Phone | | | |  | | | |
| **Medical Information** | | | | | | | | | | | |
| Medicare Card Number | |  | | Blood Type | | | | |  | | |
| Do you have any known allergies?  Please tick ALL appropriate | |  | Bees/Wasps |  | | Latex sensitivity | | | | | |
|  | Nuts |  | | No known allergies | | | | | |
|  | Herbicide sensitivity |  | | Other, please specify: | | | | | |
| Do you carry an EpiPen for your allergies? | |  | Yes | What is the expiry date on your EpiPen: | | | | | | | |
|  | No |
| Do you have asthma? | |  | Yes | Do you carry an inhaler? | | | | |  | Yes | |
|  | No |  | No | |
| Have you made a worker’s compensation claim in the past? | |  | Yes | If Yes, please provide details: | | | | | | | |
|  | No |
| Are you colour-blind? | |  | Yes | Do you require glasses for driving? | | | | |  | Yes | |
|  | No |  | No | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Licences & Certifications** | | | |
|  | **Date Obtained** | **Expiry Date** | **Licence #** |
| **Driver’s Licence** |  |  |  |
| **White Card** |  |  |  |
| **First Aid Certificate** |  |  |  |
| **Police Clearance** |  |  |  |
| **Pesticide Licence** |  |  |  |
| **Chainsaw Operation** |  |  |  |
| **Others, please list** |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**SECTION 2 | To be completed by personnel undertaking PAID WORK**

|  |  |  |  |
| --- | --- | --- | --- |
| **Direct Credit Authorisation** | | **Superannuation Details** | |
| Employee Name |  | Employee Name |  |
| Account Name |  | Account Name |  |
| BSB |  | Fund Name |  |
| Account Number |  | Membership Number |  |
| Branch |  | Fund ABN |  |
|  |  | SPIN of Super Fund |  |

# Declaration

I have attached:

* a letter or documentation from the trustee stating that this is a complying fund and (for self managed superannuation fund) a copy of documentation from the Tax Office confirming the fund is regulated.
* written evidence from the fund they will accept contributions from my employer (NAH).

Your Super will be paid via MYOB M-Powered Services. NAH is not responsible for incorrect or incomplete information, please take care when completing.

|  |  |  |  |
| --- | --- | --- | --- |
| Signed |  | Date |  |