

Stonegate Farmers Ltd, The Old Sidings, Corsham Road, Lacock, Chippenham,
Wilts. SN15 2LZ Tel. 01249 730235

APPLICATION FORM FOR EMPLOYMENT
WITHIN THE STONEGATE GROUP OF COMPANIES

Job applied for: _____ (Lacock)

PERSONAL Please complete legibly in your own handwriting

Surname	Maiden name	Forename(s)	Mr. Mrs. Miss.
Address			
Tel No.		National Insurance Number.	
Nationality	Children and ages		
Do you hold a current driving licence? YES/NO Type: HGV/PSV/CAR	Is your licence currently endorsed, if YES please give details:		
Have you ever been convicted of any criminal offences? If yes, give details below (Under the provisions of The Rehabilitation of Offenders Act 1974, you are not obliged to give any details of any spent conviction).			

Academic and Professional Qualifications

Grade/Subject	School/College/University	Date achieved

Relevant Training Courses Attended

Course	Training Provider	Date attended

EMPLOYMENT HISTORY (starting with your most recent employment)

FROM - TO	NAME & ADDRESS OF EMPLOYER/ JOB TITLE AND DUTIES	START/FINISH SALARY/ REASON FOR LEAVING

Notice Required in Current Post:

LEISURE

Please note here your leisure interests, sports and hobbies, other pastimes etc.

GENERAL COMMENTS

Please detail here your specific reasons for this application, your main achievements to date and the strengths you would bring to this post.

1. How long have you lived in the country?	Years	Months
2. If English is not your first language, please rate your English Language skills on a scale of 1 – 10 With 1.being Poor 5. Average and 10. Very Good.		



STONEGATE FARMERS GROUP OF COMPANIES

PRE-EMPLOYMENT HEALTH QUESTIONNAIRE

FULL NAME: (MR/MRS/MISS/MS)
ADDRESS:
TELEPHONE NUMBER:
NAT. HEALTH NO:
HEIGHT:
WEIGHT:
DO YOU SMOKE? YES/NO
IF YES, PLEASE STATE AVERAGE DAILY QUANTITY
IF NO, HOW LONG HAVE YOU BEEN A NON-SMOKER?
PLEASE STATE AVERAGE WEEKLY ALCOHOL INTAKE (IN UNITS)
IMPORTANT PAST MEDICAL HISTORY (details of major illness/operations/hereditary conditions or any other significant health problems)
CURRENT MEDICATION/SPECIAL DIETS (details of any medication currently being taken plus dosage, or within the last 12 months)
CURRENT DOCTORS NAME:
SURGERY ADDRESS:
SURGERY TELEPHONE NUMBER:

MEDICAL HISTORY

PLEASE TICK EITHER “YES” OR “NO”	YES	NO
A) HAVE YOU OR ANY CLOSE FAMILY EVER SUFFERED FROM FOOD POISONING, DYSENTERY, TYPHOID, ENTERIC FEVER (EG SALMONELLA), TUBERCULOSIS, OR PARASITIC INFECTIONS?		
B) HAVE YOU OR ANY CLOSE FAMILY EVER SUFFERED FROM ANY ILLNESS DURING OR AFTER A HOLIDAY WITHIN THE LAST 2 YEARS (EITHER UK OR ABROAD)?		
C) HAVE ANY OF YOUR PARENTS, BROTHERS OR SISTERS HAD ANY SERIOUS OR HEREDITARY DISORDER (EG HEART DISEASE, HIGH BLOOD PRESSURE, STROKE, DIABETES) BEFORE AGED 65?		
D) DO YOU HAVE ANY PROBLEMS BENDING, LIFTING OR STANDING FOR LONG PERIODS OF TIME?		
DO YOU HAVE ANY HISTORY OF THE FOLLOWING?		
E) HEPATITIS OR JAUNDICE?		
F) DIARRHOEA AND/OR VOMITING LASTING OVER 24 HOURS?		
G) RECURRING INDIGESTION, CONSTIPATION, ULCER, COLITIS, OR OTHER STOMACH, LIVER, PANCREAS OR BOWEL DISORDERS?		
H) SKIN CONDITIONS - ECZEMA, DERMATITIS INCLUDING SEPTIC CUTS AND BOILS?		
I) AN ALLERGY TO NUTS OR ANY OF THEIR BY PRODUCTS?		
J) BRONCHITIS OR PRODUCTIVE COUGH (with Phlegm)?		
K) ASTHMA ATTACKS OF COUGHING, WHEEZING AND CHEST TIGHTNESS. OCCUPATIONAL ASTHMA HISTORY, OR ALLERGIC REACTION IN THE RESPIRATORY SYSTEM?		
L) EPILEPSY, FITS, BLACKOUTS, MIGRAINE OR ANY DISEASE OF THE NERVOUS SYSTEM?		
M) ANY DISEASE OR DISCHARGE FROM EARS, NOSE OR OTHER SITES?		
N) ANY AFFECTION OF THE KIDNEYS OR BLADDER, URINARY PROBLEM OR DIABETES?		
O) HIGH BLOOD PRESSURE, PALPITATIONS, CHEST PAIN OR ANY HEART OR CIRCULATION PROBLEM?		
P) RHEUMATISM, ARTHRITIS OR OTHER JOINT OR MUSCLE PROBLEM?		
Q) STRESS, DEPRESSION/ANXIETY STATE, MENTAL BREAKDOWN OR ANY PSYCHIATRIC DISORDER?		
R) ANY DEFECT OR DISEASE OF THE EYES EG COLOUR BLINDNESS, GLASSES, PARTIAL BLINDNESS?		
S) MUSCULAR-SKELETAL DISORDERS? (injuries to back or limbs including slipped disc, repetitive strain injury)		
T) HAVE YOU AT ANY TIME BEEN DIAGNOSED AS BEING AN ALCOHOLIC OR DEPENDENT ON DRUGS OF ANY FORM?		

IF THE ANSWER IS "YES" TO ANY OF THE ABOVE PLEASE GIVE DETAILS

I have no objection to being referred to the Company Doctor/Occupational Health or the Company contacting my own Doctor for further investigation of any existing medical conditions or injury I may have if this is required in order to make a decision regarding possible or continuing employment with this Company.

I agree to provide any samples or specimens that may be required in order to ensure than I am not a carrier of any organisms which may infect food.

SIGNED:
(EMPLOYEE)

DATED: