

**IN CONFIDENCE
DEPARTMENT OF JUSTICE
NORTHERN TERRITORY CORRECTIONAL SERVICES**



**APPLICATION FOR EMPLOYMENT AS AN
EXPERIENCED PRISON OFFICER**

ALICE SPRINGS CORRECTIONAL CENTRE

Please read all instructions contained in the Application Pack Information Booklet prior to completing the application.

Ensure that all questions and sections contained in the Application are fully answered.

As an applicant, the provision of any incorrect or false information or the withholding of any information relating to your application may adversely affect the assessment of your integrity and may result in the rejection of your application, or the cancellation of your appointment.

INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED

Applicant Name: _____
Position Number: **15597** Experienced Prison Officer

DCIS TO COMPLETE:

Date Received: _____ Received By _____

All information must be in the applicant's own handwriting using **black biro**.

SECTION I – PERSONAL DETAILS

SURNAME: _____ Given Name(s): _____

Other Name(s): _____

Postal Address: _____

Residential Address _____

Telephone: _____ (H) _____ (B)

_____ (M) Best Contact: 1. 2. 3.

Date of Birth: ____ / ____ / ____ Place of Birth: _____

Current Occupation: _____

Current Employer: _____

Drivers Licence Class: _____ Number: _____ Expiry: _____ State: _____

Please list details of any sports, hobbies, clubs, community organisations and/or committees you are involved in: _____

Nominated Alternate Contact (Optional): _____

Next of Kin: _____ (Name in Full)

Address: _____

Telephone: _____ (H) _____ (B)

Mobile: _____ Relationship: _____

Are you: Aboriginal Torres Strait Islander Both

Consent Statement

I consent to the Department of Justice collecting personal information about me including sensitive information of a racial or ethnic origin, my criminal history including spent convictions and health information. I declare that to the best of my knowledge and belief the information given in this application is true and complete and I understand that I may be required to serve anywhere in the Northern Territory and be transferred between institutions of Northern Territory Correctional Services. I acknowledge that if I fail to respond to all questions, if I knowingly or wilfully give false or misleading information or withhold any information, it could result in (1) rejection of my application (2) removal from the register or (3) dismissal.

Signature: _____ **Date:** ____ / ____ / ____

DEPARTMENT OF JUSTICE

SECTION II – EDUCATION AND TRAINING

Highest secondary education level completed: _____

List any further education, formal qualifications or trade qualifications you have completed:

Do you hold a current Senior or Intermediate First Aid Certificate Yes No

If Yes: Issued By: _____ Issue Date: _____

List any special qualifications/skills/knowledge.

Which of the following computer applications are you familiar with?

Word Excel Email Internet Other (please specify): _____

SECTION III – EMPLOYMENT HISTORY

| Type FPC | Position/Occupation | Dates of Employment | Employer | Reason for Leaving |
|----------|---------------------|---------------------|----------|--------------------|
| | | From: To: | | |
| | | From: To: | | |
| | | From: To: | | |
| | | From: To: | | |
| | | From: To: | | |
| | | From: To: | | |
| | | From: To: | | |
| | | From: To: | | |
| | | From: To: | | |

Additional employment information attached

SECTION III – EMPLOYMENT HISTORY Continued...

Please list details of any military or police service: _____

SECTION IV - REFEREES

WORK (last two years)

| | 1. | 2. |
|---|----|----|
| Name in Full | | |
| Position | | |
| Employer | | |
| Length of Association | | |
| Telephone Number to contact Referee during Business Hours | | |

PERSONAL (non related)

| | 1. | 2. |
|---|----|----|
| Name in Full | | |
| Occupation | | |
| Nature of Association | | |
| Length of Association | | |
| Telephone Number to contact Referee during Business Hours | | |

Please tick box if written references are attached

SECTION VII – MEDICAL INFORMATION: Self Assessment Form

Surname: _____ Given Name(s): _____

DOB: _____ Sex: M F Height (cm): _____ Weight (kg): _____

Do you have or have you EVER had any of the following (circle No or Yes):

| | | | |
|--|----------|--------------------------------------|----------|
| 1. Asthma or Breathing Difficulty | No / Yes | 15. Arthritis of any form | No / Yes |
| 2. Diabetes | No / Yes | 16. Chronic bone or joint conditions | No / Yes |
| 3. Epilepsy, fits, seizures, convulsions | No / Yes | 17. Liver or Kidney Condition | No / Yes |
| 4. Blackouts, fainting, dizziness | No / Yes | 18. Rheumatic Fever | No / Yes |
| 5. Heart Disease | No / Yes | 19. Stomach/Duodenal Ulcer | No / Yes |
| 6. Palpitations/irregular heartbeat | No / Yes | 20. High Cholesterol/Triglyceride | No / Yes |
| 7. Chest pain, angina | No / Yes | 21. Gout | No / Yes |
| 8. High blood pressure | No / Yes | 22. Any heat/heat stroke condition | No / Yes |
| 9. Injuries, including head or back | No / Yes | 23. Joint/Muscular Pain | No / Yes |
| 10. Migraines or persistent headaches | No / Yes | 24. Chronic Cough | No / Yes |
| 11. Surgery (including laser surgery) | No / Yes | 25. Lower back pain | No / Yes |
| 12. Mental Illness or related condition | No / Yes | 26. Hernia | No / Yes |
| 13. Anxiety or Depressive Illness | No / Yes | 27. Deafness or Hearing Defects | No / Yes |
| 14. Stress related disorder/condition | No / Yes | 28. Physical Disabilities | No / Yes |

If you answered **Yes** to any questions, please supply details (use number reference) :

Details _____

Details _____

Details _____

Details _____

Details _____

When was your last medical check up: _____ Who is your regular doctor: _____

Do you take any prescribed medications: No / Yes If Yes, please list medication and reason :

Do you undertake regular physical activity: No / Yes If Yes, please describe activity and regularity:

Are you currently undergoing any medical or psychological treatment? No / Yes If Yes, give details:

Do you have any other conditions that may prevent you from participating in a strenuous course of physical training including running, self defence techniques, circuit/weights, team sports? No / Yes

If Yes,
details: _____

SECTION VII – MEDICAL INFORMATION: Medical Authorisation

Surname: _____ Given Name(s): _____

D.O.B.: _____

You are required to sign the following waiver in the presence of your Medical Practitioner

I, _____ of _____
FULL NAME – BLOCK LETTERS ADDRESS

in compliance with the application requirements for the position of Prison Officer in Training, and whose signature appears below, authorise

_____ of _____
MEDICAL PRACTITIONER ADDRESS

to provide Department of Justice, Northern Territory Correctional Services with information concerning my medical history. I confirm I have provided my completed medical self assessment and full details of fitness assessment criteria to my medical practitioner

_____ DATE
APPLICANTS SIGNATURE

NOTICE TO MEDICAL PRACTITIONER

Department of Justice, Northern Territory Correctional Services seeks individuals who can comply with national health and fitness standards for its prison officer workforce.

Candidates will be undertaking physical performance tests involving measurements of upper body strength, lower back and abdominal strength, aerobic capacity, agility and flexibility. Full details of the assessment criteria and procedure will be supplied to you by the applicant, along with a completed medical self assessment

The purpose of the examination is to provide medical clearance for the applicant to undertake the prescribed fitness assessment. By signing the attached medical assessment you are certifying that you received the full details of the fitness assessment and considered these details when making your assessment, and also that you have read and do not dispute any statements made by the applicant in their medical self assessment.

Please indicate if the applicant has suffered from any of the conditions listed, and provide additional comments regarding the severity, occurrence or nature of the condition. Please record blood pressure.

* Please indicate if you believe the applicant has a condition other than those listed which may affect their ability to participate in the fitness assessment without risk to their health.

SECTION VII – MEDICAL INFORMATION: Medical Assessment

Surname: _____ Given Name(s): _____

D.O.B.: _____ How long has this person been a patient of yours? _____

| Medical Condition/Illness | Y / N | Comments |
|---------------------------------|----------|-----------|
| Difficulty in Breathing | Y / N | |
| Asthma | Y / N | |
| Heart Condition | Y / N | |
| Pain or Tightness of Chest | Y / N | |
| High Blood Pressure | Y / N | |
| Blood Pressure Reading: | Systolic | Diastolic |
| Stroke | Y / N | |
| Dizziness | Y / N | |
| Disorientation | Y / N | |
| Arthritis | Y / N | |
| Lower back problems | Y / N | |
| Stress related illness | Y / N | |
| Headaches | Y / N | |
| Migraines | Y / N | |
| Anaemia | Y / N | |
| Blood Noses | Y / N | |
| Epilepsy/Seizures | Y / N | |
| Iron Deficiency | Y / N | |
| Other* (see note previous page) | Y / N | |

I have read the documents detailing the content of the fitness assessment in full and in my opinion this person **IS / IS NOT** able to participate in the prescribed fitness assessment without risk to their health

I have read the medical self assessment and the statements made within **DO / DO NOT** contradict any record or knowledge I have of this person's medical status or history.

COMMENT:

| | |
|--|--|
| | |
| | |
| | |

Signature of Medical Practitioner _____

Date _____

Name _____

Provider Number _____

Address

SECTION VIII – ACKNOWLEDGEMENT AND INFORMED CONSENT

I acknowledge I have been provided with and have read and fully understood the requirements of the Fitness Assessment which is a part of the selection process. Any questions I had in relation to physical components, criteria required levels or any other element of the Fitness Assessment have been answered to my satisfaction

Signature

Date

I hereby voluntarily give consent to engage in a fitness test. I understand that the cardiovascular fitness test will involve progressive stages of increasing effort and that at any time I may terminate the test for any reason. I understand that during some tests I may be encouraged to work at maximum effort and that at any time I may terminate the test for any reason.

I understand there are certain changes which may occur during the exercise test. They include abnormal blood pressure, fainting, disorders of heart beat, and very rare instances of heart attack. I understand that every effort will be made to minimise problems by preliminary examination and observation during testing.

I understand that I am responsible for monitoring my own condition throughout testing, and should any unusual symptoms occur, I will cease my participation and inform the test administrator of the symptoms. Unusual symptoms include, but are not limited to: chest discomfort, nausea, difficulty in breathing, and joint or muscle injury.

Also, in consideration of being allowed to participate in the fitness tests, I agree to assume all risks of such fitness testing, and hereby release and hold harmless **Northern Territory Correctional Services**, and their agents and employees, from any and all health claims, suits, losses, or causes of action for damages, for injury or death, including claims for negligence, arising out of, or related to my participation in the fitness assessments.

I have read the foregoing carefully and I understand its content. Any questions which may have occurred to me concerning this informed consent have been answered to my satisfaction.

Your Signature

Date

Your Name

Witness Signature

Date

Witness Name

Witness Contact Number

SECTION IX - APPLICANT CHECKLIST

- Section I - Completed in Full, Consent Signed
- Sections II to V - Completed in Full
- Section VI - Firearms Licence Certification Signed and Dated
- Section VII - Medical Self Assessment Completed in Full
- Section VII - Medical Authorisation Signed by both parties
- Section VII - Medical Assessment Completed, IS/IS NOT and DO/DO NOT clearly indicated by medical practitioner and signed.
- Section VIII - Informed Consent signed and witnessed
- Section IX - Attachment Checklist details completed, attachments secured
- Section X - Traffic, Criminal and other offences completed in full

Attachment Checklist

COPIES OF ESSENTIAL DOCUMENTS

DOCUMENT

| | | |
|--------------------------|---|---|
| <input type="checkbox"/> | Birth Certificate | 1 |
| <input type="checkbox"/> | Drivers Licence | 2 |
| <input type="checkbox"/> | Resume | 3 |
| <input type="checkbox"/> | Proof of Citizenship or Permanent Residency (only required if NOT born in Australia) | |

COPIES OF OPTIONAL/ELECTIVE DOCUMENTS

DOCUMENT

| | | |
|--------------------------|---|--|
| <input type="checkbox"/> | Certificates, Formal Qualifications, Trade, Further Education and Courses | |
| <input type="checkbox"/> | School Certificate | |
| <input type="checkbox"/> | Senior/Intermediate First Aid Certificate | |
| <input type="checkbox"/> | Written References | |

ANY OTHER ATTACHMENTS (PROVIDE DETAILS)

| | | |
|--------------------------|--|--|
| <input type="checkbox"/> | | |
| <input type="checkbox"/> | | |
| <input type="checkbox"/> | | |
| <input type="checkbox"/> | | |

DO NOT WRITE ON THIS PAGE