Tims Dairy
...good food from the heart of the Chilterns

JOB APPLICATION FORM

Anglo House
Bell Lane Office Village
Little Chalfont
Buckinghamshire
HP6 6FA

Tel: 01494 541 890
Fax: 01494 541 891
www.timsdairy.co.uk
Email: hr@timsdairy.co.uk

Personal Details		
First name(s):		
Surname:		
Address:		
		Postcode:
Telephone No. Home:	**Mobile:**	
Email:		
Date of application:		
Job you are applying for:		
Are you legally eligible to work in the UK?	**Yes**	**No**
Do you have a National Insurance number?	**Yes**	**No**

Employment history

Please list your previous employment with the most recent job first

Dates	Employer	Duties

Qualifications and Training

Please give details, including dates, of your qualifications and training

Additional information

Please use this section to give any other information which you feel is relevant to your application such as: skills, abilities, personal qualities, leisure activities or experience.

Comments

Signed: **Date:**

To comply with the Food Safety Regulations please complete, sign and date the attached Employee Health Questionnaire.

EMPLOYEE HEALTH QUESTIONNAIRE

Employment with TIMS DAIRY LTD.

Please answer all the questions below with regard to your general state of health

This form is a requirement under the Food Safety Regulations and will be treated in the strictest confidence

QUESTIONS (please tick YES or NO)

		YES	NO
1	Have you now, or have you over the last seven days, suffered from diarrhoea and /or vomiting?		
2	At present, are you suffering from:		
	a) Skin trouble affecting hands, arms or face?		
	b) Boils, stys or septic fingers?		
	c) Discharge from eye, ear, gums or mouth?		
3	Do you suffer from:		
	a) Recurring skin or ear problems?		
	b) Recurring bowel disorder?		
4	Have you ever had, or are you known to be a carrier of Typhoid or Paratyphoid?		
5	In the last 21 days have you been in contact with anyone, home or abroad who may have been suffering from Typhoid or Paratyphoid?		
6	Do you suffer from severe and persistent headaches and/or migraine attacks?		
7	Do you suffer from any form of Epilepsy or Blackouts?		
8	Do you currently wear glasses or contact lenses?		
9	Do you suffer from Hay Fever or Rhinitis?		
10	Do you suffer from breathing related illness e.g. Asthma?		
11	Do you suffer from any physical disabilities e.g. Arthritis , back problems		
12	Is your hearing to normal standard		
13	Are you registered disabled? If yes state disability		

My disability is:……………………………………………………………………………………………

………

I hereby declare that I have read and understood the questions and have answered to the best of my knowledge.

Name ______________________________

Signature ______________________________

Date ______________________________