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T: +44 (0)1536 511874
F: +44 (0)1536 310455
E: admin@rytons.com
www.vents.co.uk

**Please
attach a
passport
size photo
here**

Application for Employment

- All information given will remain strictly confidential.
- Please complete in BLOCK CAPITALS using **black** ink.
- If you are unable to complete any of the sections in the space provided, please attach a separate sheet.

Position Applied For:

Personal Details

Surname:	First Name: Middle Name(s):	Title: (delete as applicable) Mr / Mrs / Miss / Ms
Address: Post Code:	Date and Place of Birth: (optional, you are not obligated to give this information)	Marital Status: No of Children:
Telephone Number:	National Insurance Number:	
Mobile Number:	Do you require a work permit to work in the UK? YES / NO	
E-mail Address:	Work Permit Number:	
Please also attach a photocopy of your birth certificate or the photo page of your passport.		
Name, address and telephone number of next of kin or a close friend who can be contacted in an emergency: Relationship:		
Do you have a full clean driving licence? YES / NO (If no, state endorsements and dates):		
How would you get to work?		
Have you ever been convicted of a criminal offence (which is not a spent conviction within the terms of the Rehabilitation of Offenders Act 1974)? YES / NO (If yes, state offence(s) and date(s)):		
Disablement: Not Disabled <input type="checkbox"/> Unregistered Disabled <input type="checkbox"/> Registered Disabled <input type="checkbox"/> (please give details)		
Is there any reason why you could not wear safety headwear or footwear if required? YES / NO (If yes, give details):		
Have you ever had a serious accident at work or elsewhere? YES / NO (If yes, give details)		

If any time during the last five years is not fully accounted for in your employment record above, please account for it here:

Have you ever been dismissed from employment? YES / NO (if yes, please give details here:

Positions of Responsibility and Other Interests

Positions of responsibility (school / college or elsewhere):

Leisure interests including club memberships, societies and any form of public service:

Please give details of any commitments, which might limit your working hours e.g. judicial, military etc:

What, in particular, appeals to you about working for Rytons?

Which specific qualities do you possess that you believe make you a suitable candidate for a position at Rytons?

References and Interview

References should be personal, but must not include relatives. Current employment references will be taken up separately. All information will be treated in the strictest confidence.

Name:

Name:

Profession:

Profession:

Full Address:

Full Address:

Telephone Number:

Telephone Number:

How long have you known this person?

How long have you known this person?

And in what capacity?

And in what capacity?

Please give dates of any holidays booked in the next 6 months:
Days, dates and times not available for interview:
Would you have any special needs at an interview? YES / NO (If yes, please give details):

Notice and Declaration
<p>Notice: The information given will be used for recruitment and selection purposes only. If your application proves successful, this information will be transferred to our computerised records and retained on your file.</p> <p>Should you be employed and any information you supplied prove to be inaccurate, or information has been knowingly withheld, disciplinary proceedings would be instigated.</p> <p>Declaration: The facts stated in this application are to the best of my knowledge true and I understand that any false, misleading or undisclosed information could lead to my employment with Rytons being terminated should my application be successful.</p> <p>I understand this appointment may be subject to references being satisfactory.</p> <p>Applicant's Signature: _____ Date: _____</p>

On Completion return to Mr R G Irwin, Rytons Building Products Ltd, Design House, Kettering Business Park, Kettering, Northants. NN15 6NL or bring it with you to your interview as arranged.

Attachment Check List:

- A passport size photo attached to top right corner of page 1
- A photocopy of your birth certificate **or** the photo page of your passport
- Completed Health Questionnaire

Office Use Only	
Interview Date and Time:	
Appointed / Not Appointed:	
Department:	Position:
Hours:	
Start Date and Time:	
Wage / Salary:	
Notes:	
Signed for Rytons Building Products Ltd: _____	



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Private and Confidential Health Questionnaire

The Company will honour its obligations under the Disability Discrimination Act 1995, Health & Safety at Work legislation, the Working Time Regulations 1998 and the Data Protection Act.

1. This information is for the use of the interviewing officer and Managing Director in the first instance and may be passed to a medical advisor. The form will be retained as part of the Company's **private and confidential** records. If your employment is not confirmed this form will be destroyed.
2. In accordance with legal requirements the contents will not be disclosed without your permission to any unauthorised personnel.
3. Please complete this form as accurately as possible.
4. Please print your answers or tick one of the boxes as appropriate. There is a declaration on the last page to be signed and dated.
5. There is a space provided at the end of the form for further information. If you answer **YES** to any of the following questions, **you must use this space to give details, including dates.**

Position Applied for:		
Surname:	Other Names:	Date of Birth:
G.P.'s Name and Address:		Telephone Number:

Office Use Only:

YES NO

- | | | | |
|-----|---|--------------------------|--------------------------|
| 1. | At any time has your health seriously interfered with your normal school or work activities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | In the past year have you had any sickness absence lasting more than 2 weeks? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | How many periods of sickness absences lasting more than 3 days and less than 2 weeks have you suffered in the past 2 years? | _____ | |
| 4. | Do you suffer from any intermittent health conditions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Do you suffer from any long standing illnesses, injuries or medical complaints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | Have you had any operations? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | Have you suffered any injuries at work, home, recreational or road traffic accidents? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | Do you have any allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | Do you have any problems with the following: | | |
| | a) Heart e.g. angina, high blood pressure, palpitations, leaking valves, chest pains, Raynauds Disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| | b) Chest e.g. asthma, bronchitis, TB? | <input type="checkbox"/> | <input type="checkbox"/> |
| | c) Skin e.g. eczema, dermatitis, psoriasis? | <input type="checkbox"/> | <input type="checkbox"/> |
| | d) Consciousness e.g. fits, dizziness, blackouts or fainting attacks? | <input type="checkbox"/> | <input type="checkbox"/> |
| | e) Persistent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| | f) Stomach or bowl disorders, including indigestion, ulcers and diarrhoea? | <input type="checkbox"/> | <input type="checkbox"/> |
| | g) Hernias or ruptures? | <input type="checkbox"/> | <input type="checkbox"/> |
| | h) Kidneys/bladder? | <input type="checkbox"/> | <input type="checkbox"/> |
| | i) Liver or pancreas e.g. jaundice, hepatitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | Have you ever suffered from the following: | | |
| | a) Arthritis? (if so, which joints?) | <input type="checkbox"/> | <input type="checkbox"/> |
| | b) Injuries to bones, joints, hands or fingers? | <input type="checkbox"/> | <input type="checkbox"/> |
| | c) Sports injuries? | <input type="checkbox"/> | <input type="checkbox"/> |
| | d) Strain injuries to back or neck at home or at work? | <input type="checkbox"/> | <input type="checkbox"/> |
| | e) Tennis elbow or Golfer's elbow? | <input type="checkbox"/> | <input type="checkbox"/> |
| | f) Vibration white finger? | <input type="checkbox"/> | <input type="checkbox"/> |
| | g) Carpel tunnel syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| | h) Lumbago, fibrosis, sciatica or prolapsed disc? | <input type="checkbox"/> | <input type="checkbox"/> |
| | i) Neuritis or trapped nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| | j) Shoulder problems e.g. frozen shoulder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | Have you suffered from Repetitive Strain Injury or tenosynovitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. | Do you suffer from any hearing loss? (if so, which ear?) | <input type="checkbox"/> | <input type="checkbox"/> |
| | a) Have you ever had a discharging ear? | <input type="checkbox"/> | <input type="checkbox"/> |
| | b) Have you had a perforated eardrum? | <input type="checkbox"/> | <input type="checkbox"/> |
| | c) Have you had any other ear disease? | <input type="checkbox"/> | <input type="checkbox"/> |

13. What sports have you played in the past or present?

14. List your main leisure activities:

	YES	NO
15. Have you ever suffered from any:		
a) Alcohol related illness?	<input type="checkbox"/>	<input type="checkbox"/>
b) Psychiatric or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>
c) Form of drug dependency?	<input type="checkbox"/>	<input type="checkbox"/>
d) Depression or nervous problem?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever been exposed to any health hazard at work e.g. dusts, fumes, chemicals?	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you wear glasses/contact lenses for reading or distance vision?	<input type="checkbox"/>	<input type="checkbox"/>
18. When did you last have your eyes tested? (Date:)		
19. Do you operate a VDU? (If so, how many hours per day:)	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you suffered any problems with using a VDU?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you been involved in heavy lifting?	<input type="checkbox"/>	<input type="checkbox"/>
22. Are you aware of any reason why you should avoid lifting?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you smoke? (If so, how many a day:)	<input type="checkbox"/>	<input type="checkbox"/>
24. Are you on a hospital waiting list for treatment?	<input type="checkbox"/>	<input type="checkbox"/>
25. Are you taking any medication at present?	<input type="checkbox"/>	<input type="checkbox"/>
a) From your doctor?	<input type="checkbox"/>	<input type="checkbox"/>
b) Self-prescribed?	<input type="checkbox"/>	<input type="checkbox"/>
c) For recreational purposes?	<input type="checkbox"/>	<input type="checkbox"/>
26. Are you undergoing any form of medical treatment including physiotherapy, chiropracty, osteopathy, acupuncture? (Or in the last 2 years)	<input type="checkbox"/>	<input type="checkbox"/>
27. Have you ever suffered from any type of food poisoning, including enteritis, diarrhoea or vomiting lasting more than 48 hours, including:	<input type="checkbox"/>	<input type="checkbox"/>
a) Salmonella/typhoid?	<input type="checkbox"/>	<input type="checkbox"/>
b) Dysentery?	<input type="checkbox"/>	<input type="checkbox"/>
c) Campylobacter/Cryptosporidia infection?	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you ever lived or spent significant time abroad? If so, have you ever suffered from any tropical diseases?	<input type="checkbox"/>	<input type="checkbox"/>
29. Are there any medical conditions you wish The Company to be aware of in confidence or which may require special consideration at work?	<input type="checkbox"/>	<input type="checkbox"/>
30. In an average week, how much of each of the following do you drink? (Beer/Lager:) (Wine:) (Spirits:)		
31. If you have ever had vaccinations for the following, give approximate dates: (Tetanus:) (TB:) (Polio:)		
32. What is your: (Height:) (Weight:)		

