



APPLICATION FORM 2009

Please complete and return by 30 November 2008 to:

Phone: 0800 475 455
 Fax: 06 323 9514
 email: agnztraining@pggwrightson.co.nz

Destination Dairy
Agriculture New Zealand
Private Bag 10002
Feilding

PERSONAL DETAILS			
		<i>Last Name</i>	
		<i>First Name(s)</i>	
<i>Date of birth:</i>		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 19 <input type="text"/> <input type="text"/> <small>day month year</small>	Male <input type="checkbox"/> Female <input type="checkbox"/>
<i>Home Address</i>		<i>Postal Address: (if different from home address):</i>	
<i>Phone: ()</i>		<i>Fax: ()</i>	
CITIZENSHIP AND RESIDENCY:			
Tick the box which best describes your citizenship or permanent residency status.			
<i>New Zealand Citizen</i> <input type="checkbox"/>		<i>Australian Citizen</i> <input type="checkbox"/>	
<i>New Zealand Permanent Resident</i> <input type="checkbox"/>		<i>Other (please specify)</i> <input type="checkbox"/>	

FEE SCHOLARSHIP			
Do you wish to apply for the Fee Scholarship? Yes <input type="checkbox"/> No <input type="checkbox"/>			
DECLARATION			
Declaration – I declare that to the best of my knowledge all the information supplied on this application form is true and complete.			
_____		_____/_____/_____ <i>Date</i>	
<i>Signature</i>			

Office Use Only:

Received on _____	OUTCOME: <input type="checkbox"/> ACCEPTED
Receipt sent to applicant on _____	<input type="checkbox"/> ON WAITING LIST
Sent to Selection Panel on _____	<input type="checkbox"/> UNSUCCESSFUL
Outcome Notified to Applicant on _____	Interviewed on _____
Signed _____	Interviewer _____

EDUCATION

What was your last year at secondary school?

What high school(s) did you attend? _____

What is the highest academic award you hold from a secondary school?

NZQA Number _____

EMPLOYMENT

Have you ever worked before?

YES

NO

If yes, give us some details:

Employer	What were you doing?	Why did you leave?
1		
2		

What have you learnt from the jobs you have held?

Have you had any practical farming experience?

YES

NO

If yes, provide some details.

What is your greatest ambition? Where would you like to be in 2 years time?

DESTINATION DAIRY TRAINING PROGRAMME

How did you hear about the Destination Dairy?

What is your understanding of how the Destination Dairy Programme runs?

What are you hoping to gain by completing the Destination Dairy Training Programme?

FAMILY

Do you live with your parents/family or independently? _____

If at home, have you ever lived away from home before? YES NO

Tell us about your family?

How do you & your family feel about you living & training away from home?

INTERESTS / HEALTH / GENERAL

What interests do you have? Do you play any sport or have you in your recent past?

Do you have a driver's licence? YES NO

Are you working towards getting a driver's licence? YES NO

If yes, what type? _____

Do you have your own car? YES NO

Do you smoke? YES NO

Have you been in trouble with the Police in the last 3 years? YES NO

If yes, tell us about it. _____

How would you rate your level of reading and writing?

	Poor									Excellent
Reading	1	2	3	4	5	6	7	8	9	10
Writing	1	2	3	4	5	6	7	8	9	10

REFEREE

Who could we contact for a reference about you? (not an immediate family member)

Name _____

Relationship _____

Phone _____

STUDENT MEDICAL QUESTIONNAIRE

Do you suffer (or have you ever suffered) from:

Epilepsy or blackouts?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Diabetes?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
High Blood Pressure?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Heart Complaints?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Anxiety / depression?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
ADHD?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Other psychological disorders?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Asthma / bronchitis?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Reactions to stings / bites?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Other Allergies?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Hepatitis A or B?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Colour blindness?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Any other ailments?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Fear of heights?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____

Details (how bad)

Have you ever had an injury, strain or pain:

to finger/wrist?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
to neck, shoulder, back?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
to limbs?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____

Details (how bad)

Have you ever had:

An ACC claim for any injury?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Skin rashes, dermatitis, eczema?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____
Other medical/health problems?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____

Do you smoke?

YES NO

If you are currently being treated for any health problem, please give details below:

Do you need to have your medication with you?

YES NO **Details:**

I acknowledge that I currently have no work related injury or ACC claim that would preclude me from carrying out the training and tasks I would be required to perform as a trainee on this programme.

I acknowledge that the personal information supplied in this form is obtained for the purposes of protecting my health and safety while attending this training programme'

I declare to the best of my knowledge the answers to the questions in this health assessment are correct and I understand that if any false information is given or material fact suppressed, my inclusion in some parts of this programme may be at risk.

Signed _____ (applicant) Date _____