STAFF RECORD FORM

(TO BE PLACED IN THE EMPLOYEE RECORD)

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| **Date:** |  | **Employee number**: |  |

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| **Staff Details**  |
| **Organisation name (Employer):** |  |
| **Full name:** |  |
| **Residential address:** |  |
| **Postal address (if different from above):** |  |
| **Phone/mobile:** |  |
| **Email address:** |  |
| **Date of birth:**  |  |
| **Emergency Contact** |
| **Contact person:** |  |
| **Phone/mobile:** |  |
| **Relationship:** |  |
| **Medical Conditions** |
| **Details of condition:** |  |
| **Actions to manage the medical condition/symptoms presenting:** |  |
| **Medication prescribed:** |  |
| **Medication location:** |  |

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| **Qualifications and Classification (as per work history):** |
| **Position appointed:** |  |
| **Classification level:** |  |
| **Commencement date:** |  |
| **Increment date:** |  |
| **Ceased employment date:** |  |
| **Early Childhood Teacher:** |
| **Qualifications:** |  | **Certified copy provided:** |[ ]
| **VIT registration number:** |  | **Expiry date:** |  |
| **VIT registration (Employer Portal):** | **Teacher’s details have been added to the portal:**  |[ ]
| **Weekly hours of employment:** |  |
| **Teaching/contact time:** |  |
| **Non-teaching/non-contact time:** |  |
| **Total hours:** |  |

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| **Early Childhood Educator (diploma qualified/Certificate III**): |
| **Qualifications:** |  | **Certified copy provided:** |[ ]
| **Classification level:** |  |
| **Working With Children Check (WWCC) number:** |  | **Expiry date:** |  |
| **WWC Check sighted and approved as suitable:** |[ ]  **Employee has updated place of employment on their WWCC account:** |[ ]
| **Other (please specify):** |
| **Classification level:** |  |
| **WWCC sighted and approved as suitable:** |[ ]  **Employee has updated place of employment on their WWC Check account:** |[ ]
| **Nominated supervisor** |
| I, [Insert name], accept the designation of Nominated Supervisor of [Organisation name] and understand and accept my responsibilities under the Education and Care Services National Law and National Regulations. |
| **Signature of approved provider:** |  | **Date:** |  |
| **Signature of Nominated Supervisor:** |  | **Date:** |  |
|  |  |  |  |
| **Person in Day-to-Day Charge**  |
| I, [nsert name], accept the designation of Person in Day-to-Day Charge of [Organisation name] and understand and accept my responsibilities under the Education and Care Services National Law and National Regulations. |
| **Signature of approved provider:** |  | **Date:** |  |
| **Signature of Nominated Supervisor:** |  | **Date:** |  |
| **Designated Educational Leader** |
| **Name:** |  |

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| **Approved Training**  |
| **First Aid certificate (including emergency asthma and anaphylaxis):** |  | **Certified copy provided:** |[ ]
| **Cardiopulmonary****resuscitation (CPR) training:** |  | **Certified copy provided:** |[ ]
| **Child protection training:** |  | **Certified copy provided:** |[ ]