Clear Line
Rawson Spring Way
Sheffield
S6 1PG
United Kingdom

Visit www.clear-line.co.uk
Telephone 0044 (0)114 231 5444
Fax 0044 (0)114 251 7375
E-mail enquiries@clear-line.co.uk

Potential Subcontractor Pre-Qual

We ask everyone to complete this questionnaire carefully and to the best of their ability before they work for Clear Line.

The information you provide will be held on our personal files for the purpose of payment, training records, CRB and security checks. We will not divulge personal information as per the Data Protection Act 1998, unless you indicate that you have a medical condition that warrants special consideration in the workplace, or in the event of an emergency.

You must immediately update us if your circumstances change. Most critical items to update us include:

1. Medical conditions that we should be aware of or may affect your ability to work.
2. A change in emergency contact names of contact numbers.
3. A change in your home address (so we send monthly tax statements – charges are made for copies).
4. Additional skills or training that you have gained.

It is essential that site managers see all original documents that are to be photocopied.

If you have any problems or queries related to this questionnaire, please feel free to contact us.

Completed forms should be sent to our head office at the address above.

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JOB TITLE	

START DATE	

TITLE	
SURNAME	
FIRST NAME(S)	

HAVE YOU EVER BEEN KNOW BY ANY OTHER NAMES? YES ☐

IF 'YES' PLEASE COMPLETE THE BELOW DETAILS:

TITLE	
SURNAME	
FIRST NAME(S)	

PLEASE PROVIDE YOUR ADDRESS HISTORY FOR THE LAST 5 YEARS (MOST RECENT FIRST)

ADDRESS HISTORY			
NUMBER, STREET			
POST TOWN			
COUNTY			
POST CODE			
COUNTRY			
DATE FROM		DATE TO	

NUMBER, STREET			
POST TOWN			
COUNTY			
POST CODE			
COUNTRY			
DATE FROM		DATE TO	

PLEASE CONTINUE ON A SEPARATE SHEET IF NECESSARY

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CONTACT INFORMATION	
HOME TEL	
MOBILE TEL	
EMAIL ADDRESS	

PLEASE INDICATE WHETHER YOU PREFER YOUR REMITTANCE PAYMENT ADVICE AND CORRESPONDENCE TO GO TO YOUR EMAIL ADDRESS?

YES ☐ NO ☐

IDENTIFICATION DETAILS	
UTR (Please make sure you provide this as we cannot pay you without it)	
NI NUMBER (Please make sure you provide this as we cannot pay you without it)	
DRIVING LICENCE NO	
PASSPORT NO	
PASSPORT COUNTRY OF ISSUE	
NATIONALITY	
DOB (DD MM YYYY)	
PLACE OF BIRTH (TOWN)	
REGISTRATION DISTRICT OF BIRTH	
COUNTRY OF BIRTH	

PLEASE PROVIDE DETAILS OF ANY LANGUAGES THAT YOU SPEAK

	LANGUAGE	FLUENT	GOOD	BASIC	POOR
1ST LANGUAGE					
2ND LANGUAGE					

HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENCE OR RECEIVED A CAUTION, REPRIMAND OR WARNING? YES ☐

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NEXT OF KIN / EMERGENCY CONTACT		
NAME		
ADDRESS		
	POST CODE	
RELATIONSHIP		
CONTACT TEL NO		

PLEASE PROVIDE DETAILS OF 2 REFERENCES THAT WE CAN CONTACT

REFERENCE 1	
CONTACT NAME	
COMPANY	
POSITION	
PHONE NUMBER	
ADDRESS	

REFERENCE 2	
CONTACT NAME	
COMPANY	
POSITION	
PHONE NUMBER	
ADDRESS	

SIGNATURE	

PLEASE PROVIDE ORIGINAL IDENTIFICATION DOCUMENTS AS PER THE ATTACHED LIST

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MEDICAL QUESTIONNAIRE

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING ILLNESSES: (PLEASE TICK)

VISUAL DEFECTS / EYE CONDITIONS (INCLUDING COLOUR-BLINDNESS)	
HEARING DEFECTS / EAR CONDITIONS	
FAINTING ATTACKS, BLACKOUTS, EPILEPSY OR FITS	
VERTIGO, GIDDINESS OR TINNITUS	
HEART DISEASE OR HIGH BLOOD PRESSURE	
ASTHMA, BRONCHITIS, TUBERCULOSIS OR ANY OTHER CHEST DISEASE	
RECURRENT BACKACHE, ARTHRITIS OR RHEUMATISM	
ANY BLOOD DISORDER	
ECZEMA, DERMATITIS OR ANY OTHER SKIN CONDITIONS	
DIABETES, THYROID OR OTHER GLAND PROBLEMS	
HAYFEVER, ALLERGIES TO DRUGS, ANIMALS ETC	
ANY RECURRENT INFECTIONS	
ANY IMPAIRMENT OF IMMUNITY TO INFECTION	
HERNIA	
VIBRATION WHITE FINGER	
HAND ARM VIBRATION SYNDROME	
ANY ALCOHOL OR DRUG RELATED PROBLEMS OR ILLNESS	
CLAUSTROPHOBIA OR SEVERE MOTION SICKNESS	
BLOOD DISORDERS	
ANY OTHER MEDICAL CONDITION, PHYSICAL OR MENTAL	

HAVE YOU?

HAD MORE THAN 20 DAY'S SICKNESS ABSENCE IN THE PAST 24 MONTHS?	
EVER SUFFERED FROM AN INDUSTRIAL DISEASE/ACCIDENT?	
EVER HAD AN ACCIDENT AT A WORK PLACE?	
EVER TAKEN TIME OFF WORK DUE TO AN ACCIDENT AT A WORK PLACE?	

PRESENT HEALTH STATUS

ARE YOU CURRENTLY ATTENDING A DOCTOR?	
ARE YOU AT PRESENT ON ANY MEDICATION OR TREATMENT PRESCRIBED BY A DOCTOR?	
DO YOU HAVE ANY EYESIGHT DEFECTS OTHER THAN THOSE CORRECTED BY GLASSES?	
DO YOU HAVE ANY HEARING PROBLEMS?	
DO YOU HAVE ANY DEFECT OF SPEECH OR COMMUNICATION PROBLEMS?	
DO YOU HAVE ANY PHYSICAL DISABILITY NECESSITATING SPECIAL AIDS?	
DO YOU HAVE ANY OTHER RELEVANT HEALTH PROBLEMS?	
DO YOU HAVE ANY ALCOHOL OR DRUG RELATED PROBLEMS OR ILLNESS?	

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OPERATIVE'S TRAINING INFORMATION

TRAINING	EXPIRY DATE	TRAINING	EXPIRY DATE
H&S		1ST AID	
CWCT		CITB MANAGER	
CHERRY PICKER		NAIL GUN	
SCISSOR LIFT		CIRCULAR SAW	
MAST CLIMBER		HARNESS INSPECTOR	
GLASS VACUUM CUPS		HARNESS	
ABRASIVE WHEELS		EDGE PROTECTION	
CRAWLER CRANE		SLINGER / SIGNALLER	
PASMA		FORKLIFT	
TRAFFIC MARSHAL		IRATA 3	
IRATA 1		AP	
IRATA 2		SMSTS / SSSTS	

	TYPE
CSCS REGISTRATION NUMBER	
CPCS REGISTRATION NUMBER	

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Please rate your skills with the following construction systems using the guide below:

	EXCELLENT Received training in the construction system and install it on a regular basis	**GOOD** No formal training but install on a regular basis OR received training but have not installed the system in the last three years	**BASIC** Worked with system, but have no training and have not installed the system for the last three years	**NONE** No training with no experience
SCHUCO				
KAWNEER				
OTHER SYSTEM SUPPLIERS				
WINDOW AND DOOR MAINTENANCE				
KALZIP				
UNITISED CURTAIN WALL				
RAINSCREEN				
CLADDING				
ROOFING				
STRUCTURALLY GLAZED SYSTEMS				
CABLE SYSTEMS				
PATENT GLAZING				
SURVEYING / SETTING OUT				
STRUCTURAL SEALANT APPLICATION				
WEATHER SEALANTS APPLICATION				

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AREAS WHERE YOU ARE PREPARED TO WORK

Location	Yes/No
South West	
South East	
London	
South Wales	
North Wales	
West Midlands	
East Midlands	
East Anglia	
North West	
North East	
Scotland	
Northern Ireland	
Other EU	
Outside EU	

ALL OPERATIVES MUST SEND WITH THE COMPLETED QUESTIONNAIRE;

- **PASSPORT COPY**
- **COPY OF NATIONAL INSURANCE CARD or LETTER FROM INLAND REVENUE SHOWING NATIONAL INSURANCE NUMBER**
- **VISA OR PROOF OF RIGHT TO WORK IN UK (IF APPLICABLE)**

ORIGINALS SHOULD BE SEEN BY ON SITE CLEAR LINE SUPERVISOR.

Declaration

I declare that, to the best of my knowledge, the information I have provided is correct and that if my circumstances change I will immediately notify Clear Line.

I understand that failure to complete and attach the documents as stated will result in non-payment.

Giving false information may result in termination of my work with Clear Line.

Operative's Signature …….. Date ……

Print Name ……..

(If Applicable)
Site Manager's Signature …….. Date ……

Print Name ……..
(Only sign if seen original supporting documents)

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For Office Use Only

Information Complete	**YES**	**NO**
All Certificates Attached	**YES**	**NO**
Inland Revenue Letter	**YES**	**NO**
Passport Copy	**YES**	**NO**
Visa (if applicable)	**YES**	**NO**

Notes

Checked and entered on system by:

Name: ……..