EMPLOYEE MEDICAL DECLARATION FORM

Q1.	Are you aware of any circumstances regarding your health or capacity to work that would interfere with your ability to perform the duties of the position? *In answering this question Yes or No you are also covering factors such as: existing or exposure to infectious diseases, taking of medication/treatment on a regular basis (daily, weekly, monthly)If yes, what adjustments do you need to perform the genuine and reasonable requirements of the employment (if any)?"*
NO[ ]	YES[ ], if yes, please provide details.
	_____
	_____
	_____
	_____
Q2.	Do you have an existing injury or condition or pre-existing injury or condition that could be affected by the nature of the proposed employment? *Existing is a condition for which treatment is still being received. Pre-existing is where an injury or condition/s is present but treatment is not required. If yes please provide details of the injury or condition(s).If yes, what adjustments do you need to perform the genuine and reasonable requirements of the employment (if any)?"*
NO[ ]	YES[ ], if yes, please provide details.
	_____
	_____
	_____
	_____
Q3.	Are you taking any medication that could be important for us to know in case of emergency?
NO[ ]	YES[ ], if yes, please provide details.
	_____
	_____
	_____
	_____
Q4.	Do you suffer from or carry any infectious disease or illness?
NO[ ]	YES[ ], if yes, please provide details.
	_____
	_____
	_____
	_____

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Please place a tick YES or NO in each column to indicate if you have previously had or presently have any of the following:

	Y	N		Y	N
Any heart complaint			Presistent Headaches		
Rheumatic Fever			Hearing Problems		
Chest Pain			Eye Disease		
High Blood Pressure			Dermatitis/Skin Disease		
Shortness of Breath			Allergy to Penicillin, anaesthetic		
Artificial valve/ Pacemaker			Excessive bleeding/ blood disease		
Hepatitis, Jaundice, liver disease. What type?			Allergy to any medication/other		
HIV/AIDS			Gastric Ulcer		
Diabetes			Gout		
Thyroid Disease			Arthritis		
Tuberculosis			Bowel Disease/Complaint		
Epilepsy			Gall Bladder Disease		
Fits			Hip, knee or joint replacement		
Fainting			Back injury		
Blackouts			Spinal Injury		
Emphysema			Neck Injury		
Wheeziness/bronchitis			Bone Fractures		
Pneumonia			Mental Illness		
Asthma			Paralysis		
Any other respiratory disease			Do you Smoke?		
Nervous System Disorders			Have you ever been hospitalised?		

Have you ever been on Workers Compensation? Yes No
If yes, please specify the following:
Part of body injured_____
Approximate date of injury: __ /__ /____
Did you receive a lump sum settlement? Yes No
Did you receive a final medical clearance Yes No
Additional space to enter detail if required:

_____

_____

EMPLOYEE DECLARATION

Name: _____ of *(address)* _____

do sincerely declare that the contents of this form are true and correct and complete to the best of my knowledge and no information concerning my past or present state of health has been withheld. I hereby agree to undergo a health assessment by a medical practitioner if deemed necessary.

I understand that any wilfully incorrect or misleading answer or material omission which relates to any of the questions before mentioned may make me ineligible for employment, or if employed, liable to disciplinary action which may include dismissal. I understand that this pre-employment health declaration may form part of my file.

Applicant's signature _____

Date: ___ / ___ / _____