PRE-EMPLOYMENT MEDICAL QUESTIONNAIRE

**We will not contact your Doctor without your prior written consent.**

**This form should be completed after the offer of employment has been made and the offer is subject to satisfactory medical clearance. You are advised not to terminate present employment, if any, until clearance has been given.**

**In completing this form we expect you to be honest.**

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| --- | --- |
| Full Name |  |
| Address for correspondence with post code. |  |
| Contact Telephone number with area code(s) |  |
| How many days of absence, through illness or injury have you had from work in the last year? |  |
| Are you currently on any medication? (Excluding Contraceptives) | YES/NO | If Yes, please provide details. |
| Have you spent time in hospital in the last three years? | YES/NO | If Yes, please provide details. |
| Do you suffer from any injury, illness, medical condition or allergy that might affect your ability to perform your duties with us? | YES/NO | If Yes, please provide details. |
| Do you consider yourself to have a disability? | YES/NO | If Yes, please provide details. |
| I certify that I have answered the above questions honestly and fully and I am not otherwise aware of any physical or mental disability that may affect my work ability. I am aware that any false or incomplete statement may affect my appointment or future employment.  |  |
| Signed: | Date: |