

STRICTLY P

FIDENTIAL

Title of post applied for:

Job Ref:

Please write clearly in black ink or type.

### 1. PERSONAL DETAILS (BLOCK CAPITALS)

Surname:

Address:

<Town>

Telephone:

Height (metres)

### 2. GENERAL PRACTITIONER'S DETAILS

Name:

Address:

<Town>

### 3. EQUALITY ACT 2010

Do you have a physical or mental impairment which has a substantial and long-term adverse effect on your normal day-to-day activities?

The Equality Act 2010 defines a person with a physical or mental impairment which has a substantial and long-term adverse effect on your normal day-to-day activities.

If yes, what facilities/adjustments/equipment do you need to perform the role?

Do you have a disability under the

☐ Yes  
☐ No

Do you have a physical or mental impairment which has a substantial and long-term adverse effect on your normal day-to-day activities?

Do you need facilities/adjustments/equipment to perform the role?

#### 4. MEDICAL CONDITIONS

**Have you ever had any of the following?**

**answered 'yes' please give details.**

1	Epilepsy, fits, blackouts, fainting turns unexplained loss of consciousness?
2	Vertigo, dizziness, giddiness, problems with balance?
3	Recurrent headache or migraine?
4	Diseases of the nervous system e.g. neuritis, stroke, multiple sclerosis?
5	Angina, heart disease or breathlessness?
7	Raised or low blood pressure?
9	Asthma, bronchitis, emphysema, pneumonia or any other lung disease?
10	Jaundice or any form of hepatitis or other liver problem?
14	Psoriasis, eczema, allergic skin rash or other skin disorder?
16	Anxiety/depression, mental breakdown stress related problems?
20	Any operations or surgical procedures?
21	Ear trouble or infected ear?
22	Diabetes?
23	Kidney trouble or urinary infection?
24	Anxiety, depression or any other mental health condition?
25	Peptic, gastric or duodenal ulcer?
26	Any other serious illness not covered above?

[illegible]

Is your eyesight normal (with glasses/contact lenses)?

☐ Yes ☐ No

Is your hearing normal?

☐ Yes ☐ No

[Are there any medical reasons why you should not exercise?]

☐ Yes ☐ No

[Are you able to carry out strenuous physical carrying>>]

climbing ladders, bending, lifting and

## 5. PAST MEDICAL HISTORY

Have you ever had to give up a previous job due to health problems? If YES, please provide brief details.

If YES, please provide

☐ Yes ☐ No

Have you been off work continuously for more than five years? If YES, please provide details.

If YES,

☐ Yes ☐ No

Do you regularly take tablets or medicine?

☐ Yes ☐ No

Has any previous occupation caused you health problems? If YES, please provide details.

If YES, please provide details.

☐ Yes ☐ No

Are you in receipt of a medical pension or other financial support? If YES, please provide details.

If YES, please provide

☐ Yes ☐ No

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## 6. DECLARATION

I am willing to undergo a medical examination and I declare that the information given in this questionnaire is true and complete.

I will notify you immediately if any of my answers change.

Name:

\$

I declare that the information given in this

questionnaire is true and complete.

Date:

The Company will treat information provided in this questionnaire in accordance with its Data Protection policy. Information on how data is used and the basis of processing is provided in the [Job Applicant Privacy Notice] **AND/OR** Data Protection policy.

I agree with its Data Protection policy. Information on how data is used and the basis of processing is provided in the [Job Applicant Privacy Notice] **AND/OR** Data Protection policy.