kent

MEDICAL STATEMENT OF HEALTH

CANDIDATE DETAILS		
First Name:	Surname:	
Full Home Address:		
Date of Birth:	Position Applied for or Role on Site:	Date Completed:

QUESTIONNAIRE

The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake your duties in the workplace. We may recommend adjustments or assistance as result of this assessment to enable you to do the job. Our aim is to promote and maintain the health of all people at work.

If YES to any question below, please provide further information in the box on the right.

1. Do you have any illness/impairment/disability (physical or psychological) which may affect your work?	☐ YES ☐ NO	
2. Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?	☐ YES ☐ NO	
3. Are you having, or waiting for treatment (including medication) or investigations at present which may affect your work?	☐ YES ☐ NO	
4. Do you think you may need any adjustment or assistance to help you to do the job?	☐ YES ☐ NO	
5. Have you ever been considered medical unfit for any previous employment?	☐ YES ☐ NO	
6. Are you at present suffering from or have suffered in the last five years from any of the following?	☐ YES ☐ NO	

YES, to any question below, please provide further information in the box on the right.			
Defective vision	☐ YES	☐ NO	
Fits/blackouts/fainting attacks/epilepsy	☐ YES	☐ NO	
Back strain or trouble/pain	☐ YES	☐ NO	
Epilepsy	☐ YES	☐ NO	
Varicose veins	☐ YES	☐ NO	
Severe hay fever or any other allergy	☐ YES	☐ NO	
Diabetes	☐ YES	☐ NO	
Serious injury/accident	☐ YES	☐ NO	
Are you registered disabled or do you have any disability which you consider would impact on the job for which you are applying?	☐ YES	☐ NO	
Please indicate if you have any disabilities which affect:	☐ YES	☐ NO	
Standing	☐ YES	☐ NO	
Manual handling	☐ YES	☐ NO	
Walking	☐ YES	☐ NO	
Use of your hands	☐ YES	☐ NO	
Bending/stretching	☐ YES	☐ NO	
Climbing stairs	☐ YES	☐ NO	
Hernia Rupture	☐ YES	☐ NO	
High Blood Pressure	☐ YES	☐ NO	
Arthritis or knee/hip replacement	☐ YES	☐ NO	
List any medication that you are taking:			

DECLARATION	
I hereby declare that all the above answers are, to the best of my belief, true and complete and I have not withheld any information which would help in determining my medical fitness. I also hereby declare that I will inform a supervisor of any injury or ailment subsequently sustained to me since completing this form. I understand that failure to disclose any material information could lead to my access being revoked.	
Signed By Candidate:	**Date:**