PROMEDICA24
We care

HEALTH ASSESSMENT FORM

Full Name: _____

Job Requirements: *Please read the enclosed Job Description for an outline of your main duties and answer this questionnaire with relation to these tasks where applicable.*

GP's Name & Full Address: _____

_____

How many days sickness did you take in the last year? _____

If you are a smoker - how many cigarettes do you smoke per day? _____

If you drink alcohol - how many units do you drink per week? _____

(approximately 1 pint = 2 units; 1 short = 1 unit; 1 glass of wine = 1 unit)

Do you have a disability or health condition that could have an impact on your capability to perform the tasks required in this job role? ☐ Yes ☐ No

Briefly state the nature of your disability or health condition and how it might impact on your employment or cooperation. Please outline what reasonable workplace adjustments might be required.

_____

_____

_____

_____

_____

Have You Ever Experienced Any Of The Following:

			If **Yes** Give Details If Applicable
Epilepsy, fits, fainting or loss of consciousness	☐ Yes	☐ No	
Severe headaches or migraines	☐ Yes	☐ No	
Mental illness	☐ Yes	☐ No	
Fears or Phobias	☐ Yes	☐ No	
Sight problems, colour-blindness or eye disorders	☐ Yes	☐ No	
Deafness, hearing difficulties or ear disorders	☐ Yes	☐ No	
Back, neck or limb problems	☐ Yes	☐ No	
Rheumatism or arthritis	☐ Yes	☐ No	
Respiratory conditions	☐ Yes	☐ No	
Heart or Circulatory conditions	☐ Yes	☐ No	
Digestive or Stomach conditions	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Skin conditions	☐ Yes	☐ No	
Allergies, including hay fever if it significantly affects your daily life	☐ Yes	☐ No	
Any other significant illnesses or medical conditions that affect your ability to carry out the tasks required by your job	☐ Yes	☐ No	
Do you have any condition requiring surgery or awaiting hospital treatment?	☐ Yes	☐ No	
Have you had any serious injuries?	☐ Yes	☐ No	
Do you regularly take any kind of medication or receive any type of medical treatment?	☐ Yes	☐ No	
Have you received any medical treatment from your GP in the last three years?	☐ Yes	☐ No	
Have you attended hospital or an outpatient clinic in the last three years?	☐ Yes	☐ No	
Have you ever had any major operations?	☐ Yes	☐ No	
Have you ever suffered from any work-related health condition?	☐ Yes	☐ No	
Have you ever left, or been denied a job on health grounds?	☐ Yes	☐ No	
Have you ever been treated for abuse of an addictive substance?	☐ Yes	☐ No	

I declare that my answers to all of the questions in this medical form are true to the best of my knowledge. I accept that if it is subsequently shown that I did not disclose medical information or made misleading or false claims regarding my health that may impact on my ability to carry out my job properly and safely, that I become liable to disciplinary proceedings which may include dismissal.

I understand that, subject to my consent, further medical information may be requested from my doctor if considered necessary. I may also be required to attend a consultation and / or physical examination with a doctor in order to assure Promedica24 and it entities that I am medically fit to undertake the job that I have been offered.

I understand that Promedica24 and its entities will retain this form where it will be filed confidentially in my personnel file and that if my employment comes to an end at any time, this form will be confidentially destroyed. I agree to notify Promedica24 and its entities if my health changes in any way that may affect my ability to undertake the tasks required within my job role at Promedica24 and its entities.

In accordance with the Equality Act 2010, Promedica24 and its entities will make every effort to make reasonable workplace adjustments to enable the recruitment of applicants and continued employment of staff with a disability. I agree to inform Promedica24 and its entities of any disability that may affect my employment, and to work with Promedica24 and its entities to identify reasonable workplace adjustments where possible.

First and last name, legible signature: _____

Place, date: _____