|  |  |
| --- | --- |
| **OFFICE USE ONLY** |  |
| FTM ID: |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |

 |

As part of our duty of care, WorkPac is committed to ensuring that we do not place our employees in positions that may jeopardise their health and wellbeing. This questionnaire assists us in determining whether your current health is likely to be compromised by any assignment you may be considered for. A stringent part of WorkPac’s recruitment process is ensuring that the physical and environmental demands of a potential job are compatible with you as an individual. To do this, we need you to disclose to us all medical and health and fitness conditions you have had in the past or are currently experiencing. Please therefore complete this form in as much detail as possible. Please note that knowingly making a false or misleading disclosure about a pre-existing injury or medical condition, including by failing to tell us about an injury or condition, could put you at serious risk and result in you not being entitled to compensation or to seek damages for any event that aggravates the pre-existing injury or medical condition.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First Name:  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

 |
| Surname: |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

 |
| Date of Birth: |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | / | M | M | / | Y | Y | Y | Y |

 |

|  |
| --- |
| **Please answer the following questions regarding your current Medical Status & History** |
| 1. Are you currently being treated by any doctor?
 | [ ]  Yes | [ ]  No | 8. Have you ever had a positive Drug & Alcohol Test?  | [ ]  Yes | [ ]  No |
| 1. Are you taking any medication?
 | [ ]  Yes | [ ]  No | 9. Do you need to wear glasses for your normal work? | [ ]  Yes | [ ]  No |
| 1. Have you ever been hospitalised for any illness or had an operation?
 | [ ]  Yes | [ ]  No | 10. If so, do you have Prescription Safety Glasses? | [ ]  Yes | [ ]  No |
| 1. Have you, in the last 5 Years, had time off work because of Injury or Illness?
 | [ ]  Yes | [ ]  No | 11. Is there any reason why you cannot wear personal protective equipment? | [ ]  Yes | [ ]  No |
| 1. Have you ever had a work related injury or illness?
 | [ ]  Yes | [ ]  No | 12. Have you ever been refused life insurance, disability insurance, employment or Military Service? | [ ]  Yes | [ ]  No |
| 1. Have you ever lodged a Workers Compensation claim?
 | [ ]  Yes | [ ]  No | 13. Have you visited a Chiropractor or Physiotherapist in the last year? | [ ]  Yes | [ ]  No |
| 1. Have you ever had a sporting injury?
 | [ ]  Yes | [ ]  No | 14. Is there a family history of any medical conditions? | [ ]  Yes | [ ]  No |
| **Do you have or have you ever had any of the following conditions?** |
| 15. Asthma/Bronchitis / Lung problems? | [ ] Yes | [ ] No | 30. Diabetes? | [ ]  Yes | [ ]  No |
| 16. Allergies/Allergic to anything (e.g. Hay Fever)? | [ ]  Yes | [ ]  No | 30. Kidney Disease / Bladder Problems? | [ ]  Yes | [ ] No |
| 17. Back or neck problems? | [ ]  Yes | [ ]  No | 31. Loss of hearing / ear infections? | [ ] Yes | [ ]  No |
| 18. Blackouts or Persistent Headaches/Migraines? | [ ]  Yes | [ ]  No | 32. Malaria, other Tropical Diseases? | [ ]  Yes | [ ]  No |
| 19. Cancer or Tumour of any kind? | [ ]  Yes | [ ]  No | 33. Mental, Nervous or other psychological illnesses, conditions, or troubles? | [ ]  Yes | [ ]  No |
| 20. Deep Vein Thrombosis? | [ ]  Yes | [ ]  No | 34. Palpitations / Irregular Heartbeat? | [ ]  Yes | [ ]  No |
| 21. Depression? | [ ]  Yes | [ ]  No | 35. Other joint injuries or conditions? | [ ]  Yes | [ ]  No |
| 22. Joint Problems / Fractures or Arthritis Rheumatism? | [ ]  Yes | [ ]  No | 36. RSI / Carpal Tunnel Syndrome or Overuse Syndrome? | [ ]  Yes | [ ]  No |
| 23. Eye Trouble / Colour Vision Deficient / Legal Blindness  | [ ]  Yes | [ ]  No | 37. Shortness of Breath? | [ ]  Yes | [ ]  No |
| 24. Fits or Seizures? | [ ]  Yes | [ ]  No | 38. Skin Disorders / Dermatitis? | [ ]  Yes | [ ]  No |
| 25. Foot, Ankle or Knee Trouble? | [ ]  Yes | [ ]  No | 39. Stomach problems / Ulcers? | [ ]  Yes | [ ]  No |
| 26. Head Injury or Concussion? | [ ]  Yes | [ ]  No | 40. Suffered Blood Pressure or Heart trouble? | [ ]  Yes | [ ]  No |
| 27. Hepatitis / Jaundice / Liver trouble? | [ ]  Yes | [ ]  No | 41. Suffered from Heat stroke or Heat Exhaustion? | [ ]  Yes | [ ]  No |
| 28. Hernia? | [ ]  Yes | [ ]  No | 42. Tuberculosis? | [ ]  Yes | [ ]  No |
| 29. Injury requiring an Operation? | [ ]  Yes | [ ]  No | 43. Any other Medical or Surgical conditions? | [ ]  Yes | [ ]  No |

**If you answered ‘Yes’ to any of the above please provide details here:**

|  |
| --- |
| . |
|  |
|  |

|  |
| --- |
| **Do you have any difficulty with the following activities?** |
| 44. Concentrating for any length of time? | [ ]  Yes | [ ]  No | 54. Walking on rough ground? | [ ]  Yes | [ ]  No |
| 45. Reading ordinary print? | [ ]  Yes | [ ]  No | 55. Climbing a Ladder? | [ ]  Yes | [ ]  No |
| 46. Hearing a normal conversation? | [ ]  Yes | [ ]  No | 56. Lifting Heavy weights / objects? | [ ]  Yes | [ ]  No |
| 47. Turning your head rapidly? | [ ]  Yes | [ ]  No | 57. Using Hand Tools? | [ ]  Yes | [ ]  No |
| 48. Bending or Twisting? | [ ]  Yes | [ ]  No | 58. Working in Hot / Cold Conditions? | [ ]  Yes | [ ]  No |
| 49. Repetitive movements of the arm, legs or head? | [ ]  Yes | [ ]  No | 59. Shift Work or Sleep? | [ ]  Yes | [ ]  No |
| 50. Gripping firmly with either or both hands? | [ ]  Yes | [ ]  No | 60. Working at Heights? | [ ]  Yes | [ ]  No |
| 51. Sitting or standing for two hours? | [ ]  Yes | [ ]  No | 61. Working in Confined Spaces? | [ ]  Yes | [ ]  No |
| 52. Crouching or Kneeling? | [ ]  Yes | [ ]  No | 62. Working Above Shoulder Heights? | [ ]  Yes | [ ]  No |
| 53. Running 100 meters (in the event of an emergency)? | [ ]  Yes | [ ]  No | 63. Understanding English (e.g. Safety Procedures, instructions or Evac Plans)? | [ ]  Yes | [ ]  No |

**If you answered ‘Yes’ to any of the above please provide details here:**

|  |
| --- |
|  |
|  |
|  |

**For any past injury; work related or personal (sporting etc.), please provide details below:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Work related? | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Nature of injury: |       |       |       |
| Date of injury: |       |       |       |
| Employer: |       |       |       |
| Period off work: |       |       |       |

**The following section is mandatory and MUST be completed! Your Emergency Contact will be contacted in the event of an incident, injury or illness. Please notify WorkPac if there is a change in these details.**

|  |
| --- |
| **Emergency Contact**  |
| Name: |  | Relationship |  |
| Street Address: |  |
| Suburb: |  | State:  |  | P/Code: |  |
| Phone: |  | Mobile: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| What is your Approximate Height? | cm | Approximate Weight? | kg |

**EMPLOYEE DECLARATION**: I agree that all of the above details I have provided are true and correct and by signing below, I declare that I have not omitted any medical information nor misled my prospective employer (WorkPac) about any pre-existing injuries or my medical history. I also acknowledge that by failing to disclose any relevant information about any pre-existing injuries or medical conditions, or by misleading my prospective employer in any way, could put me at serious risk and result in me not being entitled to compensation or to seek damages for any event that aggravates the pre-existing injury or medical condition. Furthermore, I hereby provide my authorisation for WorkPac to contact my emergency contact in the event of an incident, injury or illness.

|  |  |  |  |
| --- | --- | --- | --- |
| Name:  |       | Date: | ***/ /*** |
| Signature: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Parent/Guardian Name:  |  | Date: | ***/ /*** |
| Parent/Guardian Signature: |  |

|  |
| --- |
| **OFFICE USE ONLY** |

If previous injury - has the Final Medical certificate been provided? [ ]  Yes [ ]  No

|  |  |
| --- | --- |
| RC Comments: |  |
| **RC Signature:** |  | **Date :**  |  |
| **RC Name:**  |  |  |  |