Lukka Care Homes

PRE-EMPLOYMENT MEDICAL QUESTIONNAIRE

STRICTLY CONFIDENTIAL

NAME:	DATE OF BIRTH: ……/……/…….
ADDRESS:	
POSITION APPLIED FOR:	LOCATION:
NAME & ADDRESS OF YOUR DOCTOR:	

Please answer ALL the following questions:		YES	NO
(1)	Have you suffered any of the following: (if YES please provide full details on the reverse of this form)		
a)	depression, anxiety, nervous illness or breakdown?	☐	☐
b)	epilepsy or disease of the nervous system?	☐	☐
c)	spinal problems, including back injury or strain or recurrent back pain?	☐	☐
d)	any heart or circulatory problems, including problems of the blood?	☐	☐
e)	any illness or medical condition not specified above?	☐	☐
(2)	Have you ever: (If YES, please provide full details on the reverse of this form)		
	been awarded compensation for injury sustained during the course of your employment with any previous employer?	☐	☐

(3)	Are you presently taking any medication or undergoing any treatment? If YES, please provide full details:	Yes ☐	No ☐
(4)	Are you a registered disabled person? If YES, please provide full details.	Yes ☐	No ☐
(5)	How many working days (excluding holidays) have you been absent from work in the last twelve months? Please give reasons for these absences:		

(6)	Please provide full details of any factors which could make it difficult or dangerous for you to lift (resident, equipment, boxes, etc). For example, have you ever suffered back or shoulder problems in the past? Please give full details of any other factors which could affect your ability to perform such duties in the future:
(7)	Please declare any other health matter that may affect your ability to perform your duties:
(8)	Are you vaccinated against Hepatitis B? Yes ☐ No ☐ Please provide written details including dates. If you are not vaccinated we strongly recommend that you are. Please arrange this with your GP.

PLEASE READ CAREFULLY BEFORE SIGNING:

I declare that the answers given are true and correct and give a full and complete picture of my health in every respect.

I am prepared to undergo a medical examination if this is required.

I understand and accept that if any of the information given in this document is incorrect or untrue, the Company reserves the right to immediately terminate my employment with them.

I hereby authorise you to contact my doctor to comment upon my fitness for the position for which I am applying if required by the Company:

Signed: …… *Date: ……*