EMPLOYMENT MEDICAL FORM – APPLICANT

PERSONAL DETAILS (please print)			
Surname		**Other Names**	
Date of Birth		**Best Contact Number**	
Email			
Address			

DECLARATION BY APPLICANT

The declaration below must be signed by you **in the presence of the examining doctor** during the health assessment.

Failure to disclose any relevant information relating to your ability to, and ability to safely, fulfil the inherent requirements of the role you are applying for and you are subsequently employed in that role, your employment may be terminated or a future claim for workers' compensation may be denied.

(Section 79 of the Workers' Compensation and Injury Management Act 1981 (WA) states *"Where it is proved that the worker has, at the time of seeking or entering employment in respect of which he claims compensation for an injury, wilfully and falsely represented himself as not having previously suffered from the injury an arbitrator may in the arbitrator's discretion refuse to award compensation which otherwise would be payable.")*

Please be aware that any personal, health and medical information that you provide to Northern Star medical services suppliers, medics, or other OHS personnel before and during employment with Northern Star are medical records which are the property of Northern Star.

Information about the privacy of your health and medical information is provided in the Information Email you received inviting you to this appointment. It also appears at the end of this form.

I (print name), _____ declare that:

a) I have read and understand the declaration above and the information email provided when I was asked to attend this appointment;

b) I consent to the collection, use and disclosure of my medical information explained in the information email;

c) I acknowledge my health and medical information provided to Northern Star before and during employment are the property of Northern Star;

d) I consent to clarification of medical information with my treating medical practitioner if necessary;

e) I acknowledge results will be received by Northern Star or an authorised representative.

f) I have answered all questions (including questions on any signed supplementary forms) honestly, correctly and completely.

g) I have not knowingly withheld any relevant information.

h) I understand that incorrect or misleading statements or omissions may;

i) result in the termination of any employment by Northern Star;

j) negate any future claim for compensable injury/illness.

Signature:		**Date:**	

HEALTH QUESTIONNAIRE

This questionnaire must be completed in order to help assess your ability to, and ability to safely, fulfil the inherent requirements of the role you are applying for. Please answer the questions by ticking the appropriate box or circling the appropriate response. If you are not sure, leave the question blank and ask the examining health professional what it means. The health professional will ask you more questions during the assessment.

			Doctor's Comments
1. Are you currently attending a health professional for any illness or injury?	☐ No	☐ Yes	
2. Do you suffer from or have you ever suffered from:			
High blood pressure	☐ No	☐ Yes	
Heart disease	☐ No	☐ Yes	
Chest pain, angina	☐ No	☐ Yes	
Any condition requiring heart surgery	☐ No	☐ Yes	
Abnormal shortness of breath or chest disease	☐ No	☐ Yes	
Palpitations / irregular heartbeat	☐ No	☐ Yes	
Head injury, spinal injury	☐ No	☐ Yes	
Seizures, fits, convulsions, epilepsy	☐ No	☐ Yes	
Blackouts or fainting	☐ No	☐ Yes	
Stroke	☐ No	☐ Yes	
Dizziness, vertigo, problems with balance	☐ No	☐ Yes	
Double vision, difficulty seeing, or difficulty adapting to changing light conditions	☐ No	☐ Yes	
Colour blindness	☐ No	☐ Yes	
Memory loss or difficulty with attention or concentration	☐ No	☐ Yes	
Diabetes	☐ No	☐ Yes	
Neck, back or limb disorders	☐ No	☐ Yes	
Hearing loss or deafness or had an ear operation or use a hearing aid	☐ No	☐ Yes	
Hernias	☐ No	☐ Yes	
Injuries to shoulder, elbow, wrist, hands, hip, knee, ankle or foot, including tendonitis, tennis elbow, carpal tunnel syndrome or overuse condition?	☐ No	☐ Yes	
Neck or back pain	☐ No	☐ Yes	
Joint problems	☐ No	☐ Yes	
History of back disability with more than three months off work in one episode	☐ No	☐ Yes	
A psychiatric illness or nervous disorder	☐ No	☐ Yes	
Allergic reactions (for instance, to dust)	☐ No	☐ Yes	
3. Do you have any other condition, disability or impairment that could impact your ability to, and ability to safely, fulfil the role you are applying for? Describe below.	☐ No	☐ Yes	

4. Have you ever had any other serious injury, illness, operation, or been in hospital for any reason? Describe below.	☐ No	☐ Yes	

5. The following questions relate to your intake of alcohol. Please circle the answer that is correct for you:

How often do you have a drink containing alcohol?	Never (go to Q6)	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 to 5	5 to 6	7 to 9	10 or more
How often do you have six or more drinks on one occasion?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year
Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

Doctor's Comments:

6. The following questions are about your sleeping patterns:		
Have you ever been told by a doctor that you have a sleep disorder, sleep apnoea or narcolepsy?	☐ No	☐ Yes
Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?	☐ No	☐ Yes

Please use the following scale (Epworth Sleepiness Scale) to choose the most appropriate description for each situation. The questions refer to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

How likely are you to doze off or fall asleep (rather than just feeling tired) in the following situations:	**would never doze off (0)**	**slight chance of dozing (1)**	**moderate chance of dozing (2)**	**high chance of dozing (3)**
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (e.g. a theatre or a meeting)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in the traffic	☐	☐	☐	☐

Doctor's Comments:

7. Do you smoke or have you ever been a smoker?

☐ No	
☐ Ex-smoker	Quit date:
☐ Yes	Number of cigarettes per day:

Doctor's Comments:

8. Do you use illicit drugs?

☐ No ☐ Yes

Doctor's Comments:

9. The following questions relate to how you are feeling. Please tick the answer that is correct for you:

In the past 4 weeks about how often did you:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Feel tired out for no good reason?	☐	☐	☐	☐	☐
Feel nervous?	☐	☐	☐	☐	☐
Feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
Feel hopeless?	☐	☐	☐	☐	☐
Feel restless or fidgety?	☐	☐	☐	☐	☐
Feel so restless you could not sit still?	☐	☐	☐	☐	☐
Feel depressed?	☐	☐	☐	☐	☐
Feel that everything was an effort?	☐	☐	☐	☐	☐
Feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐
Feel worthless?	☐	☐	☐	☐	☐

Doctor's Comments:

10. HAVE YOU BEEN IN A VEHICLE CRASH RECENTLY?

☐ NO ☐ YES, provide brief description:

11. CURRENT MEDICAL TREATMENTS INCLUDING MEDICATION RELEVANT TO ROLE (please list)

1.
2.
3.
Other:

HAVE YOU TAKEN ANY COUGH/ COLD MEDICATION, SLEEPING TABLETS, PAIN KILLERS OVER THE PAST 10 DAYS?

☐ NO ☐ YES (PLEASE LIST) **1.** _____ **2.** _____

WHY DID YOU TAKE THE MEDICATION:

12. CURRENT JOB (please note the doctor does not have access to your CV)

Are you currently working? ☐ No (proceed to next section 'PREVIOUS JOBS' ☐ Yes (complete details below)

Current Employer	Job Title	Start Date (Month/Year)

13. PREVIOUS JOBS (starting from most recent other than current job detailed above)

Company/Industry	Job Title	Start-Finish (Approx. Month/Year)

14. REGULAR RECREATIONAL ACTIVITIES (type & frequency e.g. Cricket twice/week)

15. FUNCTIONAL DIFFICULTIES

Any trouble with the below tasks?

	Yes	No		Yes	No
Sitting in a vehicle travelling over rough roads or terrain for long periods?	☐	☐	Wearing personal protective equipment e.g. safety boots, safety glasses, hearing protection, respiratory protection	☐	☐
Working in confined spaces or at heights	☐	☐	Travel in a small plane	☐	☐
Climbing ladders	☐	☐	Shift work – nights/days, 12hour shifts	☐	☐
Walking on rough ground	☐	☐	Hot conditions – e.g. heat stress	☐	☐
Crouching/kneeling and/or negotiating stairs	☐	☐	Repetitive work involving hands and arms	☐	☐
Lifting 20kg or heavy luggage	☐	☐	Radio communication/hearing	☐	☐
Using hand tools and carrying tool bags	☐	☐	Working with hands above head	☐	☐

Doctor's Comments:

TREATING DOCTORS e.g. Your General Practitioner (**MUST BE FILLED**)	
Name:	Address/Suburb:
Phone no:	

PRIVACY STATEMENT - HOW YOUR HEALTH INFORMATION IS COLLECTED, STORED AND ACCESSED BY NORTHERN STAR

Provisions of the *Privacy Act 1988* (**Privacy Act**) apply to Northern Star and the medical professional's practice. Northern Star maintains a privacy policy. Please contact Northern Star and the medical professional if you would like to view their privacy policies.

All your detailed medical papers including your responses in the Pre-Employment Medical Form, test results and the complete record of clinical findings are kept confidential by Northern Star and the medical professional's practice. Other than disclosure between Northern Star and the medical professional, your medical records and personal information will not be disclosed to any other person or organisation without your written permission, except when Northern Star appoints a health professional or other representative to review the information, where required by law, where required in the event of any accident, injury, sickness or claim for workers' compensation relevant to you, or where otherwise permitted by the Privacy Act. This means that your medical records and personal information may be disclosed to (accessed) and used by:

- **Northern Star employees, including employees of its related bodies corporate, acting within the scope of their duties related to occupational health and safety and injury management.**
- **Third parties authorised by Northern Star, including relevant medical practitioners, for occupational health and safety and injury management purposes.**
- **Northern Star's subsidiary companies in the United States, if employment, transfer of site or change of role is relevant to Northern Star's United States operations.**

Northern Star and/or the medical professional's practice may be obliged under the Privacy Act to permit you access to/amend or correct information that Northern Star and the medical professional's collect about you on your request. Northern Star acquires a propriety interest in the results reached (or recommendations made). Information collected by Northern Star may be disclosed to its subsidiary companies in the United States, if employment, transfer of site or change of role is relevant to Northern Star's United States operations. Please note that unauthorised use of the information released to you as part of the medical assessment, including its provision by you to a third party, is prohibited.