Instructions for applicants

All applicants who are being considered by a prospective employer for employment in the industries are required to undertake a pre-employment medical screening.

The following forms are required to be completed accurately and in full by both the applicant and the medical or health person prior to medical assessment and certification.

The completed forms must be returned to the prospective employer and a copy is retained with the issuing authority.
Section A: Applicant’s report (to be completed by the applicant)

Part I: Personal detail

<table>
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<tr>
<th>Field</th>
<th>Information</th>
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<tr>
<td>Surname:</td>
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<tr>
<td>First Name:</td>
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<tr>
<td>Nationality:</td>
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<td>DoB:</td>
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<tr>
<td>Address:</td>
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<tr>
<td>Employer:</td>
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<td>Contact No:</td>
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Part II: Personal Medical History

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>If yes, give details</th>
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<tbody>
<tr>
<td>Are you currently being treated by any doctor for any illness?</td>
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<td>Are you currently taking any medications including inhaler?</td>
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<td>Are you allergic to anything?</td>
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<tr>
<td>Have you ever spent time in hospital as a patient?</td>
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<td>Have you broken or fractured any bones?</td>
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<td>Have you ever had a disease or injury resulting from work?</td>
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<tr>
<td>Do you suffer from back, neck or spinal problems?</td>
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<tr>
<td>Have you ever had an X-Ray or scan on neck or back?</td>
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<tr>
<td>Have you, in the last 2 years, lost time from work because</td>
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<td>of illness or injury?</td>
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<td>Have you been exposed to any toxic substances or environmental hazards?</td>
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</table>
### Part III: Do you now, or have you ever had any of the following? (Please tick box)

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<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
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**Comment:**

__________________________________________________________________________________________

__________________________________________________________________________________________

**Is there any history of serious disease or illness in your immediate family?**

Yes ☐ No ☐

If yes, please provide details when you see the doctor.

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**Do you**

<table>
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<tr>
<th>Yes</th>
<th>No</th>
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</table>

- Smoke or have you ever smoked? If yes, no. of cigarettes per day ____________________________
- Take illicit drugs, if yes provide details
- Drink alcohol, if yes average number of standard drinks per week ____________________________
- Have any illness or injuries not stated above, if yes provide details __________________________

**Do you have difficulty in any of the following?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</table>

- Crouching/bending/kneeling
- Lifting heavy weights
- Working at heights
- Walking upstairs/ladders
- Walking on uneven ground
- Sitting for extended periods of time
- Shift/work/sleep
- Working in hot/cold extremes
- Standing for an extended periods of time
- Repetitive movements of hands/arms
- Working above shoulder height
- Working in confined spaces

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When and where was your last chest X-ray taken? ____________________________________________

When was your last Td injection? ____________________________________________________________

**Do you have or have ever had any other condition that may impact on your ability to safely perform the duties required to you?**

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**I hereby certify that the foregoing particulars are to the best of my knowledge correct. I authorize to release any information acquired from this examination to my employer/prospective employer or their authorized representative.**

Signature and date

Signature of witness and date
Section B; Medical examination (to be completed by a registered medical or health person)

1. Measurements

Height ____________________ Weight ________________________ BMI (if required) ______________________

Visual acuity:

Distance Vision Close Vision

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<thead>
<tr>
<th>Eye</th>
<th>Uncorrected</th>
<th>Corrected</th>
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<tbody>
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<td>Right</td>
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<tr>
<td>Left</td>
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<tr>
<td>Both</td>
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</tbody>
</table>

Colour Vision: Normal [□] Abnormal [□]
Blood pressure: ……………… mmHg Additional readings if required: ……………………
Pulse rate (resting pulse) ………………….. per min; Rhythm: Regular [□] Irregular [□]

2. General:  

a) Does the appearance correspond with the age stated?
Yes [□] No [□] Provide details if required
b) Is there anything unfavorable in appearance
Yes [□] No [□] Provide details if required
c) Give particulars of permanent marks or scars
Yes [□] No [□] Provide details if required
d) Any dermatitis, skin rash, infection
Yes [□] No [□] Provide details if required
e) Any swelling/pitting pedal oedema
Yes [□] No [□] Provide details if required

3. Respiratory system:

a) Is breathing normal and regular in character?
Yes [□] No [□] Provide details if required
b) Is there any abnormality on inspection or examination?
Yes [□] No [□] Provide details if required
c) See is there any sign of past or present respiratory disease
Yes [□] No [□] Provide details if required

4. Circulatory system:

a) Are there any abnormalities on cardiac auscultation?
Yes [□] No [□] Provide details if required
b) Is there any abnormality in the heart rate or rhythm?
Yes [□] No [□] Provide details if required
c) Is there any varicose veins?
Yes [□] No [□] Provide details if required

5. Digestive system:

a) Is there evidence of abnormality of the tongue, mouth, teeth or throat?
Yes [□] No [□] Provide details if required
b) Is there evidence of abnormality for abdominal organs, including liver and spleen?
Yes [□] No [□] Provide details if required
c) Is a hernia present?
Yes [□] No [□] Provide details if required

6. Spine and nervous system:

a) Is there evidence of disease of the brain or spinal cord?
Yes [□] No [□] Provide details if required
b) Is there any defect in sight, hearing or speech?
Yes [□] No [□] Provide details if required
c) Is the evidence of abnormality for:
   Shoulder [□] Elbows/wrist [□] Hand/hips [□] Knees/ankles [□] Feet [□] Cervical spine [□] Thoracic spine [□]
d) Reflexes:
   Is there evidence of abnormality for:
   
   Biceps  ☐  ☐
   Triceps  ☐  ☐
   Supinator  ☐
   Knee  ☐
   Ankle  ☐

7. Hearing Test:  (Note the findings)

<table>
<thead>
<tr>
<th>Ear</th>
<th>External appearance</th>
<th>Auroscopic exam</th>
<th>Rinne's test</th>
<th>Weber's test</th>
<th>Conversational hearing/whispering test</th>
<th>Audiology (please attach report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
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Normal ☐ Abnormal ☐ If abnormal, give details…………………………………………………………

7. For female candidates
   a) Menstrual history:  Menarche at ………… yrs (age) LMP………………………….  
   Menstrual irregularity, if any …………………………….
   b) Obstetric history:  Gravida …………… . Para……………………
   c) Pelvic examination  (for married women only)……………………………………
   d) Pap smear……………………………………
   e) Pregnancy test………………………

Investigations:
   a) Serological Examination  
      Hepatitis B……………..  Hepatitis C……………  HIV ……………… RPR ……………..  TPHA ………
   b) CBC  
      TLC………………..  DLC…………………….  Hb …………………..
   c) ABO Rh ……………
   d) Smear for malaria ……………
   e) Urine analysis:  Sugar …………………..  Protein ………………..  Blood ……………
   f) Electrocardiogram (if required) Normal ☐ Abnormal ☐ Report attached ☐
   g) Chest x-ray: Film No.  Normal ☐ Abnormal ☐ Report attached ☐
   h) Pulmonary Function test (where indicated):

<table>
<thead>
<tr>
<th>FVC</th>
<th>FEV1</th>
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<tbody>
<tr>
<td>Predicted</td>
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<tr>
<td>Measured</td>
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<td>% of predicted</td>
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Remarks: ……………………………………………………………
   i) Additional investigations for persons over 40 years of age (male):
      TMT  
      Echocardiogram  
      Ultrasound for prostrate

Section C:
I am of the opinion that the above mention person is :

☐ Fit for proposed employment  
☐ Fit for proposed employment with the following  restrictions;  
☐ Unfit for proposed employment

Signature and Name of the Medical or health person  ---------------

Date: …………………………………  Official seal